Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Yea **Physician** Louis Dominic Patti TIT January 21, 1999 6:10 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 15 Morning Star Court Overlea Baltimore County If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1 ☑ M 2 ☐ F 212-50-5482 Yrs Director Baltimore Md. 50 July 3,1948 Usual Rasidence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23s or 28s-f show r than "natural", or Nema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2GNo Director Maryland Baltimore Overlea 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Morning Star Court 21206 United States death Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours effer Department of Health and Mental Hygiene. Important: if flem 27 le marked other than "natural", or he any Injury or other treumatic event, the Medical Exercises any Injury or other treumatic event, the Medical Exercises and the property of the Medical Exercises. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 12 College (1-4or 5+) Restaurant Owner/Operator 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis D. Patti Jr. Antoinette V. Popoli 0 19e. informent's Neme/Relettonship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Verna M. Patti 15 Morning Star Court Baltimore, Maryland 21206 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Cremetion 3 □ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1/25/99 Most Holy Redeemer Baltimore 22. Name and Address of Facility Milton J. Knight Jr Leonard J. Ruck, Inc. 21214 5305 Harford Road Baltimore, Maryland ons that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete Intervat Between Onset end Death **APhysician** tmmediete Cause (Finel diseese or condition resulting in death) /Medical altalia renal cell concurani Examiner Physician/Medical Examir Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Cause (Disease or hjury that initiated events resulting in daeth) Last Due to (or as a consequence of): P.O. Box 68760. Dua to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, p 24b. Were autopsy tindings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? P 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpatient 3 | DOA 報 27. Menner of Death 28e. Dete of injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Affar 5 Panding Investigation Attending 1 Neturel 1 Yes 2 No Hospital or Attand 24 hours after death Funeral Director. 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29b. Signature and titla of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) urtell waan

Registrar

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EXITERY

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EVE BALTIMUPP Nd WZZY

30. Name and address of person who completed cause of beatf (Item 23a) (Type, Print)

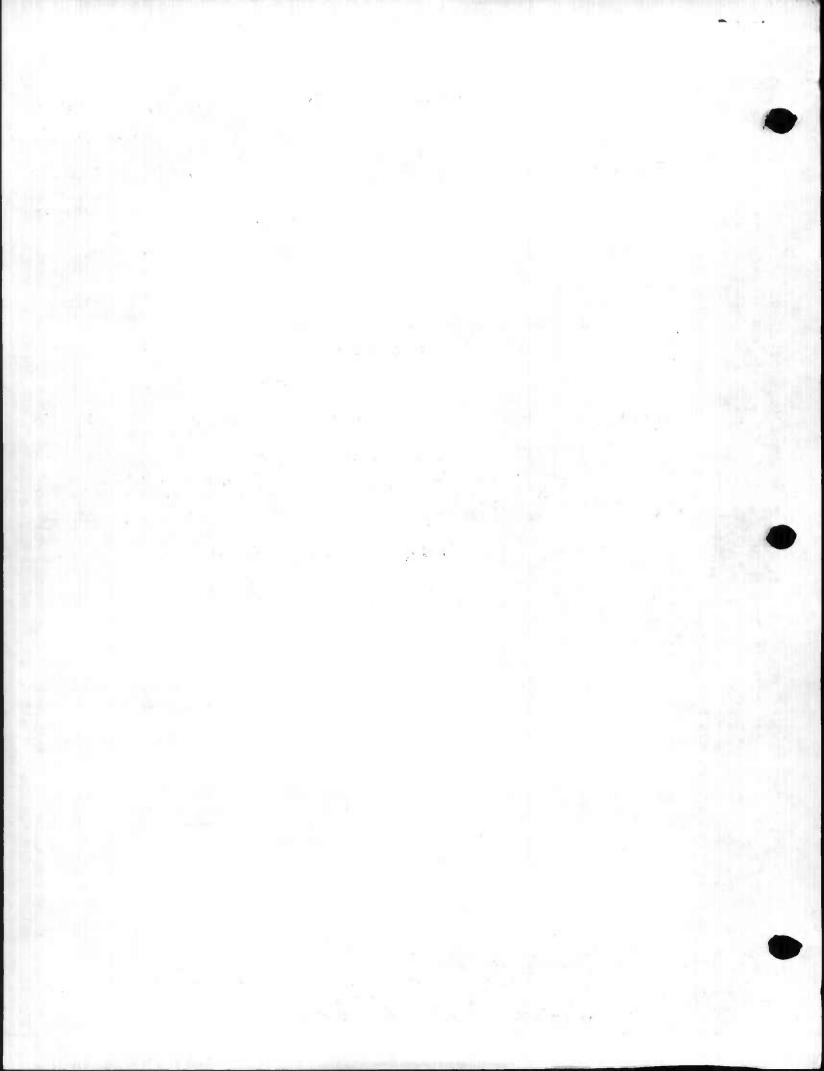
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31. Date fited (Month, Dey, Year)

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32. Registrer's Signeture



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4a Facility Neme (If not institution, give street and number) 4b. City, Town, (4c. C	County of De	eth
	LAURIE LEE	-		W I Inda	1 7-11	GLEN I					ARUNDEL	
213-	10-4237	6. Sex 1 M 2 ☐ F	7. Age (In yrs. 83	Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da MAY 17	ly, Year)		nthplaca (State or Fore Country) RYLAND
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	LAURIE LEE	LANE			101. 21	210	60				U.S.A.	
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1 Never Married 2 Married 1 Yes, Gir 3 Widowed 4 Divorced Year or D			ed Forces? If Yes, specify Cuban, Mexic		ın, Mexican,	Puerto	Rican, etc.)		Black, White, etc. Specify: WHITE			
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Elemen	ary/Secondary (0-12)	1	(1-4or 5+)	lifa. E	DO NOT u	se retired	during most	Or WORK	n'y			DEL COUNTY
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FRAN				PRALEY			AUGU					MER
Marie Control	mant's Name/Ralationsh								I Route Numb			
-	DEMETRIA F	PRALEY (WIFE)				LEE L	ANE,	-			. 21060
	od of Disposition urlat 2 Cremation	3 Removal from		Place of Dispos cemetery, crem	natory or o	other plac	ce)	1	Date	20c. Loc	ation - City o	or Town, State
	onation 5 ☐ Other (Sp			EN HAVE								
21. Signe	ure of Funeral Service L	icensee										ME, P.A.,
1	charl C	Sale	Land	1	SECO	ND A	VENUE	, S.	W., GLI	EN BU	RNIE,	MD. 21061.
23a. Part	1. Entar the disease, or k, or heart failure. List	complications that	caused the dea	th. Do not ente	er the mod	de of dylr	ng, such as	cardiac o	or raspiratory a	rrest,		Approximete Intarval Batween
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cause. E	ding to immediata hter Underlying sease or Injury		PROSTA	TE CA								1
I that initial	ed events n death) Last	C	Due to (or es e consequ	uence of):							
		u										
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1 U Y	s 25 No			ER/Outpetien			4 LI NU	-	me 5 Shes			pecify)
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	cident invastig	ation			М		Yes 2□I		and 1 - "	(0	4.44	D
	omicida detarmi	ned 28a. Place	28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify)						281. Location (City or To	(Street and wn, State)	Number or	Rural Route Number,
	k only 2 Medical E	Physician: To the xaminer: On the	basis of examina	owledga, daath ation and/or inv	occurred restigation	at tha tir n, In my c	na, data and pinlon, deat	d place, a	and dua to the ed at the time,	causa(s) data and	and manner place, and d	as stated. ua fo tha causa(s)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Elijah Rinehart, Jr. JANUARY 13 1999 03:45 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 24 Hrs. BALTIMORE ff Under 1 Year 5. Sociel Security Number Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□ F Months Days Hours Min. 217-14-2555 Director 30. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at Maryland Baltimore Towson 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 801 Scarlett Drive U.S.A. 21286 Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. TYP Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married al Hygiene. other than "natural", or 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Civil Engineer unknown Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 2 should be tand Mental It Fannie Gertrude High Elijah Rinehart 19a. Informent'a Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health as Important: If them 27 fa.s. 801 Scarlett Drive, Towson, Maryland 21286 Olive S. Rinehart/wife 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fungual Se Rope 1 d S - Wade 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Mirector Baltimore, Maryland 21201 23a. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examin Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last attending physician for use as the buna certificate be Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 8 24b. Were sutopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Wes en eutopsy performed? this certificate has 1□ Yes 2□No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 212 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28c. Injury st Work? 28d. Describe how injury occurred edical Certification: 28b. Time of 5 Panding Injury 1 Natural 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEON 5 15 141, RITOUNT AVE. BACTO DD 21286

Registrar

State

2. Registrar's Signature

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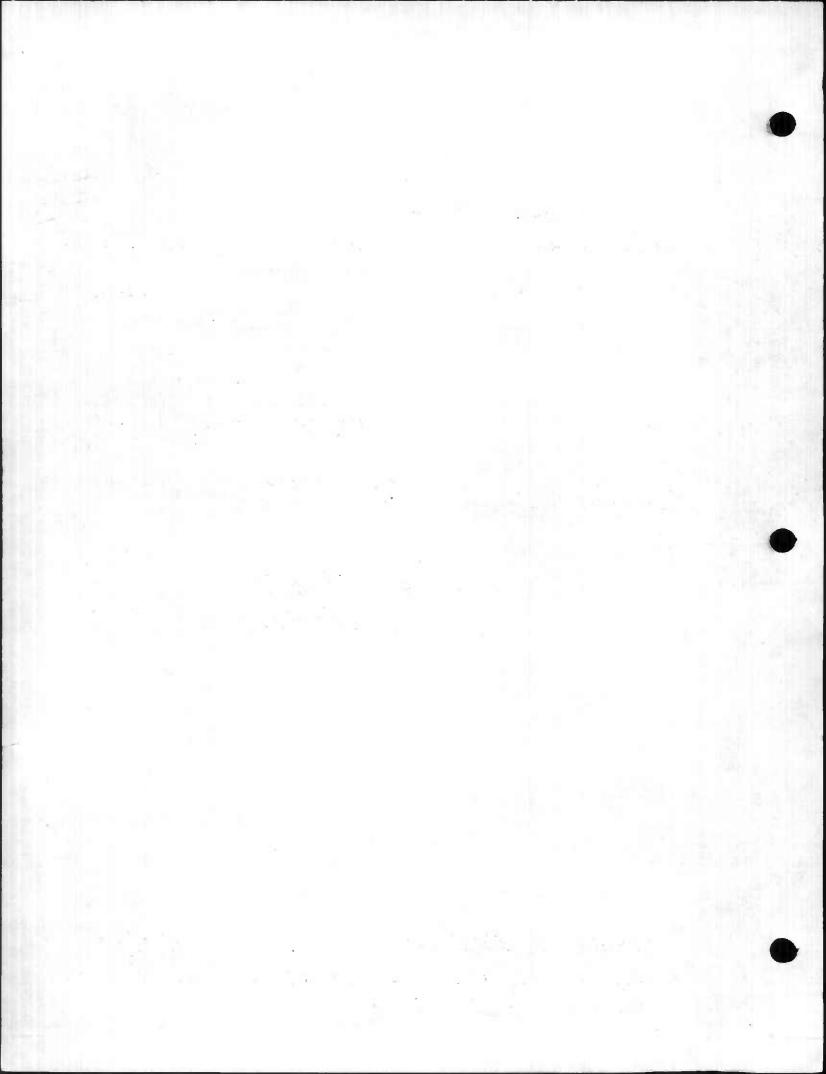
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Baltimore,

Box 68760.

P.O.

Division of Vital Records.

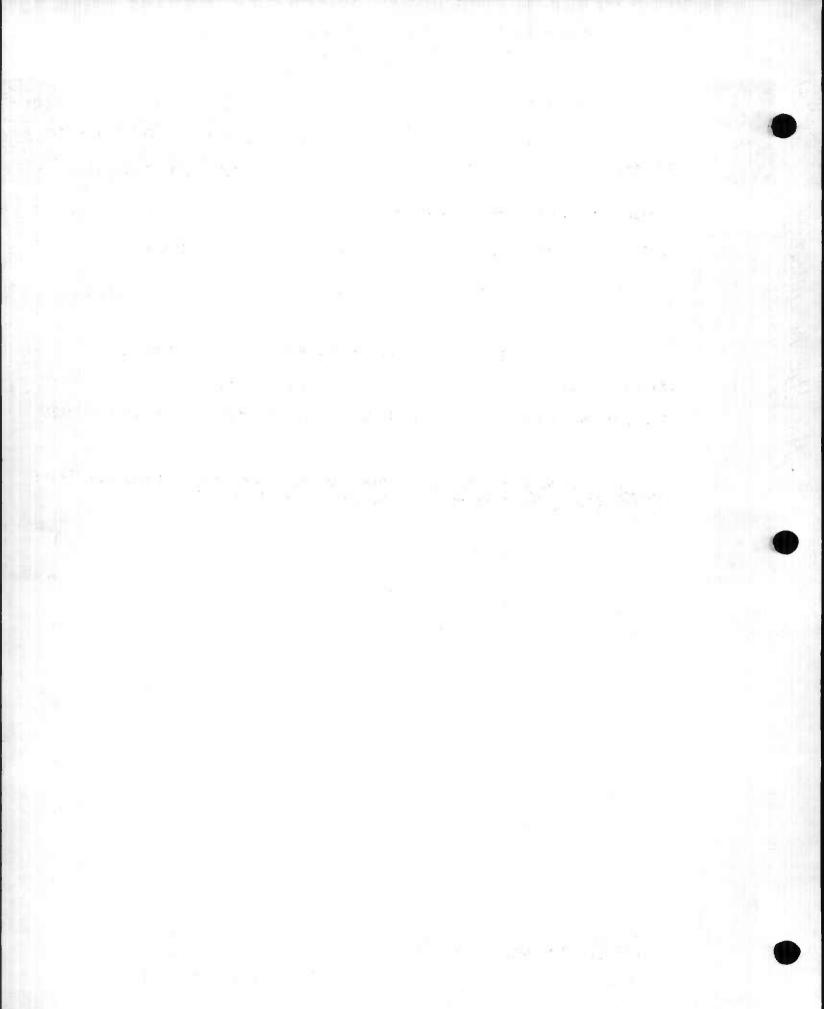


. ARRELLA Rosemond

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/Medic Examin		al 45 Ch. To						b. City, Tow	vn, or Lo	cation of Death			0 /1110
Funeral Director		5. Social Security Number 217-24-9231 6. Se	X 7.	Age (In yrs. 81	last birthdey) Yrs.	If Under Months	1 Yaar Days	If Undar 2 Hours	4 Hrs. Min.	8. Dete of Birth (Month, Det July 8	/ Year)	9. Birthp Coun Mary	place (State or Foreigntry) y Land
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3a or 28	i Direc	10e. Street and Number 2063 N. Bentalor	ı Street			10f. Zip					U.S.A.		ntry?
Deportment of nesting and whether my state in a property of them 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Deceder Armed Forca 1 Yes 2 If Yes, Give Yaar or Data:	s? 2 No		S. 13. Was Decedent of Hispanic Origin? (Spiff Yas, specify Cuban, Maxican, Puarto		in? (Sp. Puarto			ce - Amaric ck, Whita, y: Bla	etc.	
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erked other etic event,	To Be C	17. Father's Name (First, Middla, Last) William E. Davis						18. Mother		(First, Middle, Davis			
Itam 27 la m other traum		19e. Informant's Name/Relationship (T. Abiki Tyson/sist 20a. Method of Disposition	er		19b. Mailii 2401 Plece of Disponentery, createry, createry	St.	Step e of	phens	Cou	rt,Balt	ir, City or Town, Imore, M	aryla	nd 21216
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ing physician end e as the burial-transit	Medical Examiner	Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury that Initieted events resulting in death) Last	. Hyper Empt	14154	or es e consec On as a consec								
ed by the ettending p detached for use as	Physician/M	Part II. Other significant conditions co	d	but not res	sulting in the u	nderlying ca	use giv	en in Part I.			obecco use co		the cause of death
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within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai Certi	29a. Certifier (Check only 2 Medical Exam)	building, aician: To the be	etc. (Specifi st of my kno	y) owledge, deat	occurred a	it the tin	ne, date end	placa,	City or Tow	m, Stete)	enner es si	tated.
To the Funeral completely filled	Med	29b. Signature and title of certifier	and menner	stated.		29c.	Licens	a number			29d. Qate signe		
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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Alta Ruehle January 1999 2:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Arundel Spa Creek Center Annapolis If Under 1 Year | If Under 24 Hrs. | Date of Birth (Month, Day, Year) 7/2/05 Birthplece (State or Foreign Country)
 IOWa 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10 M 2 F 92 YES 480-01-0836 Director Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 23s or 28s-f show Maryland 1 Yes 2 No Anne Arundel Annapolis Director 10f. Zip Code 10e, Street and Number 10a. Citizen of What Country? 35 Milkshake Lane 21403 U.S.A. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Herrie 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Black, White, etc. 11. Maritel Stetus unknown filed within 72 hours after 1 Never Merried 2 Merried T ☐ Yas 2 ☐ No If Yes, Give X altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tile. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. ther then Elementery/Secondery (0-12) College (1-4or 5+) unknown Homemaker Own Home unknown 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be in iment of Health and Mental H fant: If hem 27 is marked off jury or other traumetic even Be Hattie Louise Anderson Joseph Henry Brown 19e. Informant's Neme/Raletlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 130 Hearne Road, Annapolis, Maryland 21401 Chuck Ruehle/son 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State Date cemetery, cremetory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any Injury or 4 Donetion 5 ☐ Other (Specify) 21. Signeture of Fune al Service Licansee 22. Nome and Address of Facility
State Anatomy Board, 655 W. Baltimore Street Rohald S. Wade Director Kill munu Baltimore, Maryland 21201 23a. Perf1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approxim*ete* Int*ervel* Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition rasulting in death) Examiner The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): ŏ signed by the at Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 250No Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? peed completion of cause of death? has page 2 certificate 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical funeral director, 25. Was casa rafarred to medicat axaminer? 26. Place of Death (Check only ona) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28d, Describe how injury occurred 28b. Time of 28c. Injury at' Work? Natural 5 Pending 1 | Yes 2 | No 2 Accidant investigetion the 3 Suicide 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 可多 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. Medical 29a, Certifier completely (Check only one) 29b. Signeture and title of cartille 29c. License number 29d. Dete signed (Month, Dey, Year) 32036 w 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Drue Chester MD 21619

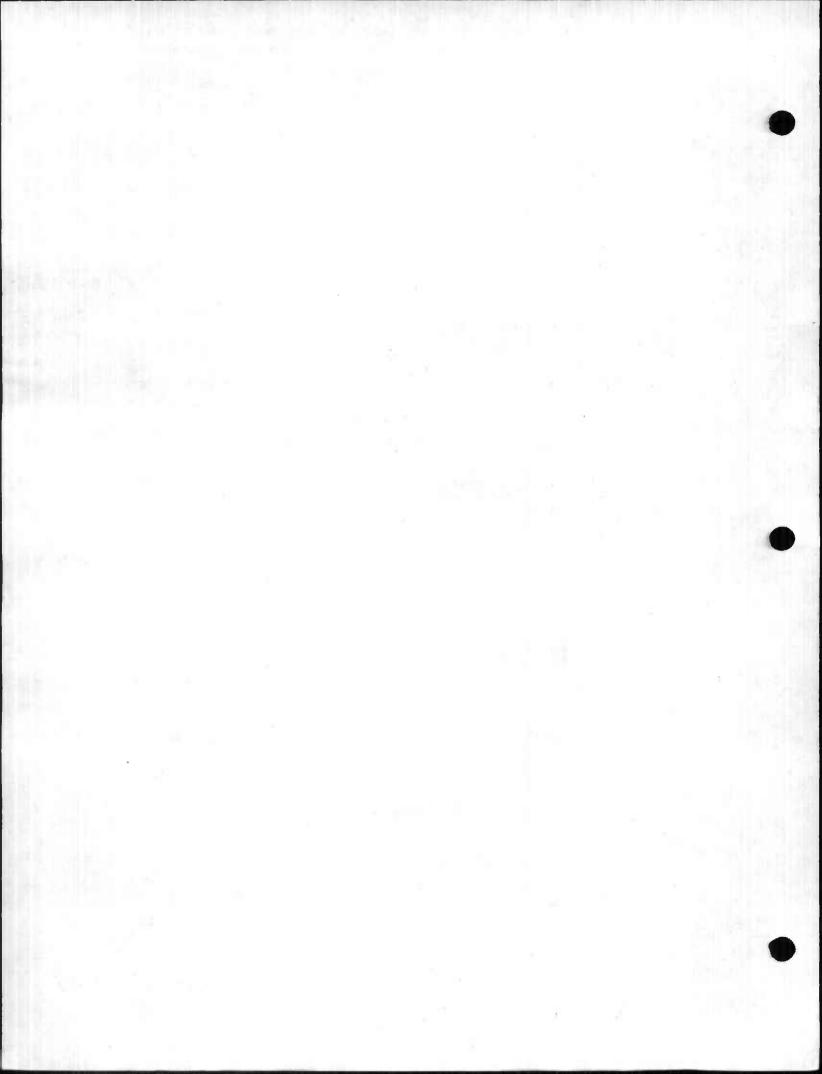
State Registrar

31. Dete filed (Month, Dey, Year)

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DHMH 16 Rev 6/95

Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 105AM EMMA ILFFV TANUARY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RANDALLSTOWN
r If Under 24 Hrs. 8. Da NORTHWEST HOSPITAL CENTER BALTIMORE COUNTY If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min 1□ M 2 F Days Hours Yrs. MARYLAND Director 217-18-3182 74 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow 7 is marked other than "natural", or flams 23s or 28s-f show traumatic event, the Medical Examiner must be notified as 1 Yes 2 No Directo MARYLAND BALTIMORE WOODLAWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23s any injury or other traumatic avent, the Medice Examples must have must 2110 LUGINE AVENUE U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondery (0-12) N/A HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 86 JOHN DAVID ROHRER EDITH GERTRUDE PARRISH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GEORGE A. REED (HUSBAND) 2110 LUGINE AVE. WOODLAWN, MARYLAND 21207 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State JAN. 25 WOODLAWN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 21. Signeture of Funeral/Service Licanser 22_Name and Address of Facility
LORING BYERS FUNERAL DIRECTORS. INC. 1100804 8728 LIBERTY RD. RANDALLSTOWN, MARYLAND 21133 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In death) Examiner consequence of) Physician/Medical Examiner weensu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, that the death certificate be Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? datached 1 Yee 2 No 3 Probably 4 Unknown à The law requires Sign B 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has b lirector, page 2 s 1□Yes 2□N 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ ₩6 Be 26. Place of Death (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Offipationt 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 Velural 28a. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: After 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. ector: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 24 hours after Funeral Direct pletely filled in b 4 Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) To the Vithin 2 To the 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) ngoted cause of death (Item 23a) (Type, Print) 30. Name and address of person who of

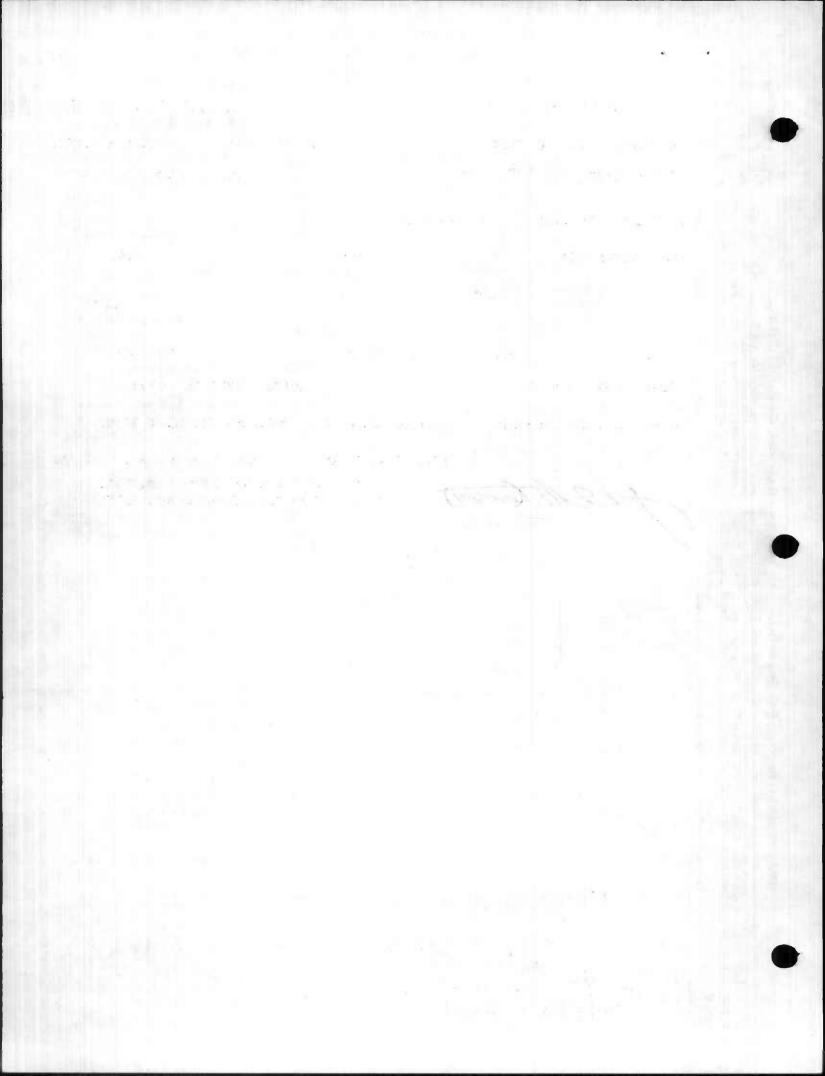
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32. Registrar's Signature

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State Registrar 31. Date filed (Month, Dey, Yeer) JAN 25 1999



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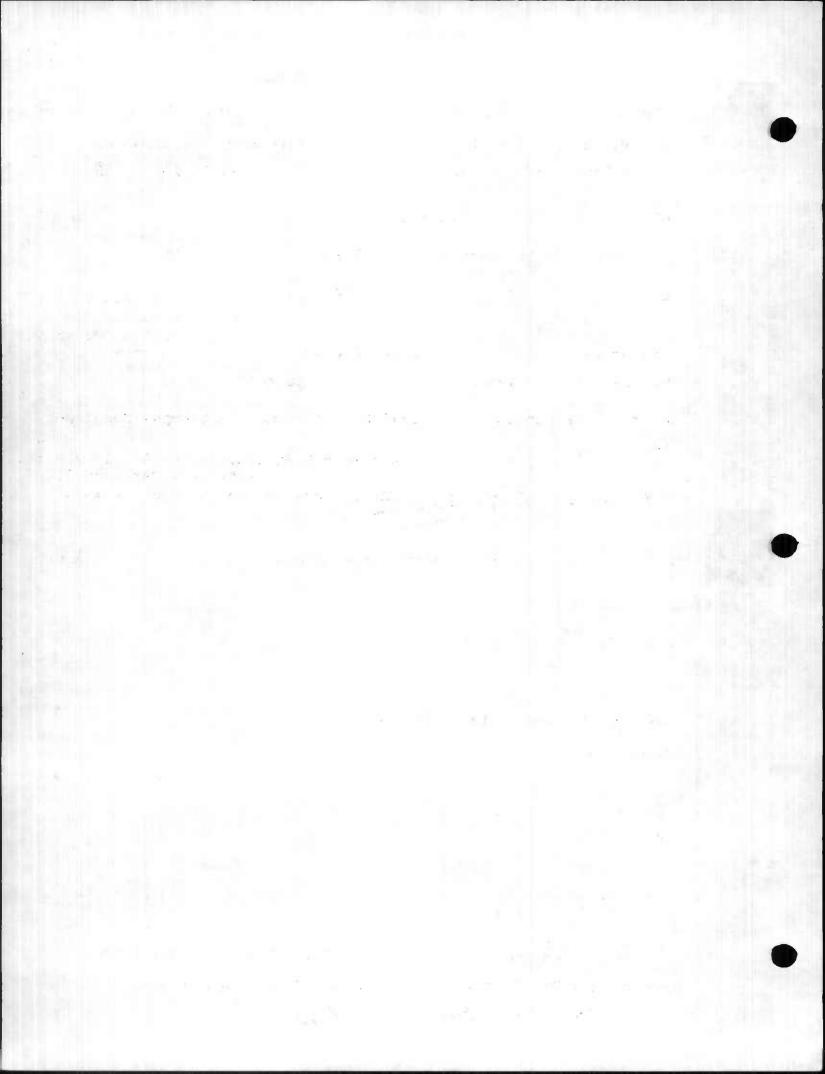
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 1999 :50a JAH NASHLEY [LOBINSON 20 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL CENTER Balt: more
If Under 24 Hrs. 8. Dat Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year) II-II-25 Birthplace (Stete or Foreign Country)
 N C 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthdey) **Funeral** 1 M 2 F Days Hours Min. 241-28-7584 73 Yrs. Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Medical Examinar mast be notified at MD Yes 2□No NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 급 21217 1540 North Fulton Avenue USA permit. Pages 1 and 2 should be filed within 72 hours effer death v. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or itema 23a any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yas or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Never Married 2 Married 3 Widowed 4 Divorced MYes 2 No If Yes, Give Year or Dates: 1 Yes ₹ No Specify: Specify:Black by Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry William Constru. Elementery/Secondery (0-12) College (1-4or 5+) Construction 6th Grade Company 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) William L. Curzell Door Robinson 19a. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 1540 Fulton Avenue Baltimore, Maryland Kathryn Robinson 20a Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State MD. Garrison Forest VA Cem. 01-26-99 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensee WM.C.March FH 1101 E. North Avenue one that caused the leath. Do not enter the mode of dying, such es cardiac or respiratory arrest, uses on each line. 23a. Part1. Enter the diseasa, or complication shock, or heart failure. List only one care Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Medica 2 Days PHEUMONI TA Sopsis Examiner Due to (or es a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attanding physician for use es the buria Box 68760 Dua to (or as a consequence of) resulting In death) Last signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cerebro vascular Disease Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? been si Completed 24e. Was en eutopsy DEMENTER certificata has b 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours eftar death.

To the Funeral Director: After this certifica completely filled in by the luneral director, 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 P No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred Certification: 5 Panding Investigation 1 Natural 1 Tyes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. 29c. Licansa number 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) AU417643559894 SETTY, MD Baltimore VA Hospital 22 S. Greene Street 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 5 1999 Registrar Sports

DHMH 16 Rev 6/95



Piease Type or Print in Black indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ▲ Item#8 per FH G768 2/4/99 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 3. Time of Death 2. Dete of Death Day Month **Physician** William Н. Sunderland 20, 1999 4c. County of Death January /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore enter osedale tranklin Square Hosbita If Undar 24 Hrs. If Under 1 Yaar 7. Age (n yrs. last birthday) 8. Deta of Birth 02-11-11 9. Birthplaca (State or Foreign (Month, Day, Year) 1-11 Country) Sacurity Number **Funeral** Months Days Min. Hours 18 M 2□ F 216-01-9499 87 Director Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ahona i 1 Yas 2 No Directo Maryland Baltimore Co. Parkville 288-1 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? "natural", or flams 23a or 21234 United States 8820 Walther Blvd. #2201 Raca - American Indien, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Yes 2 X No
If Yas, Giva
Year or Datas: 1 ☐ Nevar Married 2 ☑ Merried 1 Yas 2 No Specify: Specify by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Western Electric 12 2 should be filed w and Mental Hygier is marked other th Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be George B. Sunderland Augusta K. Krause 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) . Mrs. Irene D. Sunderland (wife) 8820 Walther Blvd. #2201 Baltimore, MD mportant: If Item 27 altimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/99 Towson, Maryland Hilltop Service Corp. 21. Signatura of Funaral Sarvice Licensee Michael E. Canapp 22. Nama and Addrass of Facility 5305 Harford Road Michel E.C Baltimore. 21214 Leonard J. Ruck, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata tritarval Batween Onset end Death **Physician** /Medical Immediata Causa (Finat disaasa or condition rasulting in deeth) cular Fibrillation Examiner Examiner Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last Due to (or as a conseque P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records. þ 24b. Ware autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yas 2 No 1 Yas 2 No Division of Vital 25. Was casa rafarred to medicat axaminar? Be 26. Placa of Death (Check only ona) Hospitat: 1 Napatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No this After this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Medical Certification: 5 Pending Invastigation To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. Attanding 1 Naturat 1 Yas 2 No 2 Accidant 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 102 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

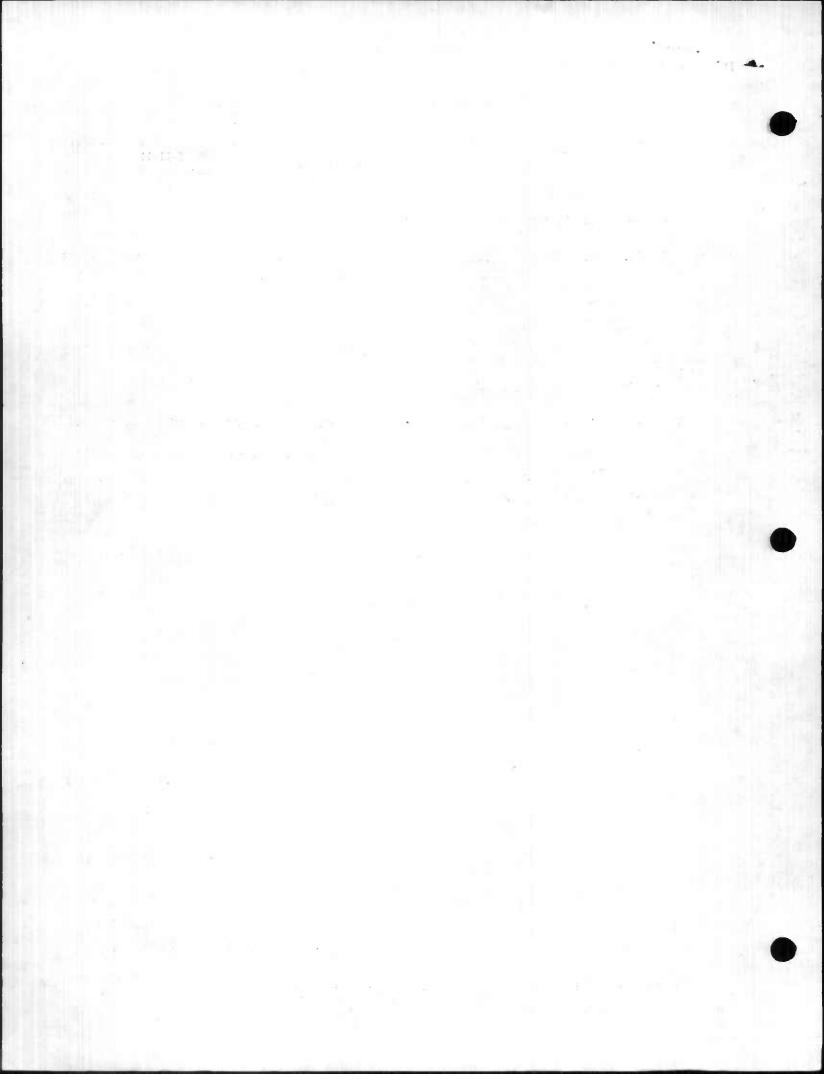
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartitiar (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifier 1005 3617 30. Name and addy of person who completed causa of death (Item 23a) (Type, Print)

State Registrar

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Nasser 9000 Franklin Square Drive Baltimore MD



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Deeth Month January **Physician** Anks ·Opm * /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number 4c. County of Deeth Examiner Medic Baltimore If Under 24 Hrs. 8. F enter MIERC Baltimore City 5. Social Security Numb 7. Aga (In yrs. last birthday) 8. Deta of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** 10M 20F Months Deys Hours Yrs. 219-16-7434 Director Nov. 23, 1925 unknown Usuet Residence of Decedent the Maryland 10e Stete 10h County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Modical Examiner must be nottled at 1 → Yas 2 □ No Director Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1213 Light Street 21230 U.S.A. Funeral death 12. Wes Decedant Ever in U,S. Armed Forces*Unknown 1 □ Yes 2 □ No If Yes, Giva Yaer or Detes: Wes Decedent of Hispenic Origin? (Specify Yas or Notif Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indien, Btack, White, etc. 11. Marital Status unknown permit. Pages 1 and 2 should be filed within 72 hours after to Department of Haalin and Mental Hybineo. Important: It liem 27 is marked other than "natural", or file any Injury or other traumatic event, it's Medical Examine 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest greda completed) Etementery/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be unknown unknown 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) Vernon Smith/brother 3226 Pressman Street, Baltimore, Maryland 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetary, cremetory or other placa) 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata 4 □ Donetlon 5 ☑ Othar (Specify)in state ²²Neme and Address of Fecility Board, 655 W. Baltimore Street 21. Signeture of Funeral Service Licansee Ronald S. Wade Director lale Baltimore, Maryland 21201 tomen BATLIMOTE, MATYIAITU 21201

blications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximete Intervet Between Onsat end Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner sician end burial-transit Sequantially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of): certificate be exec physician the burial Box 68760 Physician/Medical Due to (or es a consequence of) attending esn esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the cause of death? P.0. been signed by the should be detached Seizure Disorder 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings eveilable prior to complation of cause of death? Dehydration Completed 24e. Wes en eutopsy performed? 1 Tes 20 No this certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) axaminer? 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Coutd not be determined 3 Suicide 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier (Check only one) ertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

2 | Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. Medical 29b. Signature and title of centile 29c. License number 29d. Date signed (Month, Dey, Year) Mercy Medical Center

State Registrar

JAN 25 1999

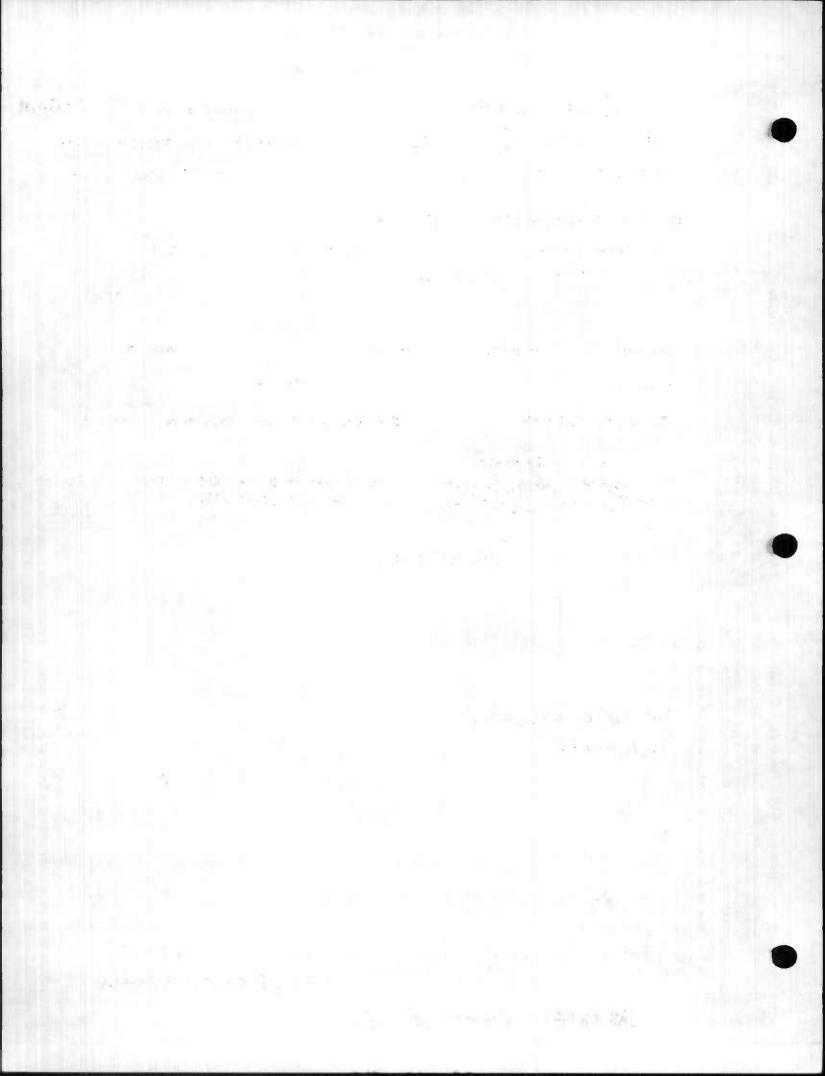
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end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 43 pm Audrey Sheri 100 MURY 5, 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore City naryland General Baltimore City 5. Social Security Number Dale of Birth (Month, Day, Year) If Under 24 Hrs. 8. Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) Year) Months Days Hours 1□ M 2☑ F 218-18-1520 79 1919 unknown Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Ves 2 □ No Baltimore Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21201 501 West Franklin Street 12. Was Decedent Ever in U.S. Armed Forces? unknown 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify: 14. Rece - American Indian. Black, White, etc. 1⊠ Never Married 2 Married Black 3 ☐ Widowed 4 ☐ Divorcad 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) unknown unknown 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licens Ronald S. W 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Wade Director mel Muss Baltimore, Maryland 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shorts, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence ot) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lasl Due to (or as e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical exeminer? 26. Piece of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of 1 (Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

physician and s the bunal-transit the death certificate be axecuted P.O. Box 68760, attending ph for use as t ed by the a The law requires that peed s cartificate hes b director, page 2 s Attending Physician: director After this funeral deeth. eftar deeti Director: 2 ò

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29a. Certifier

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> State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

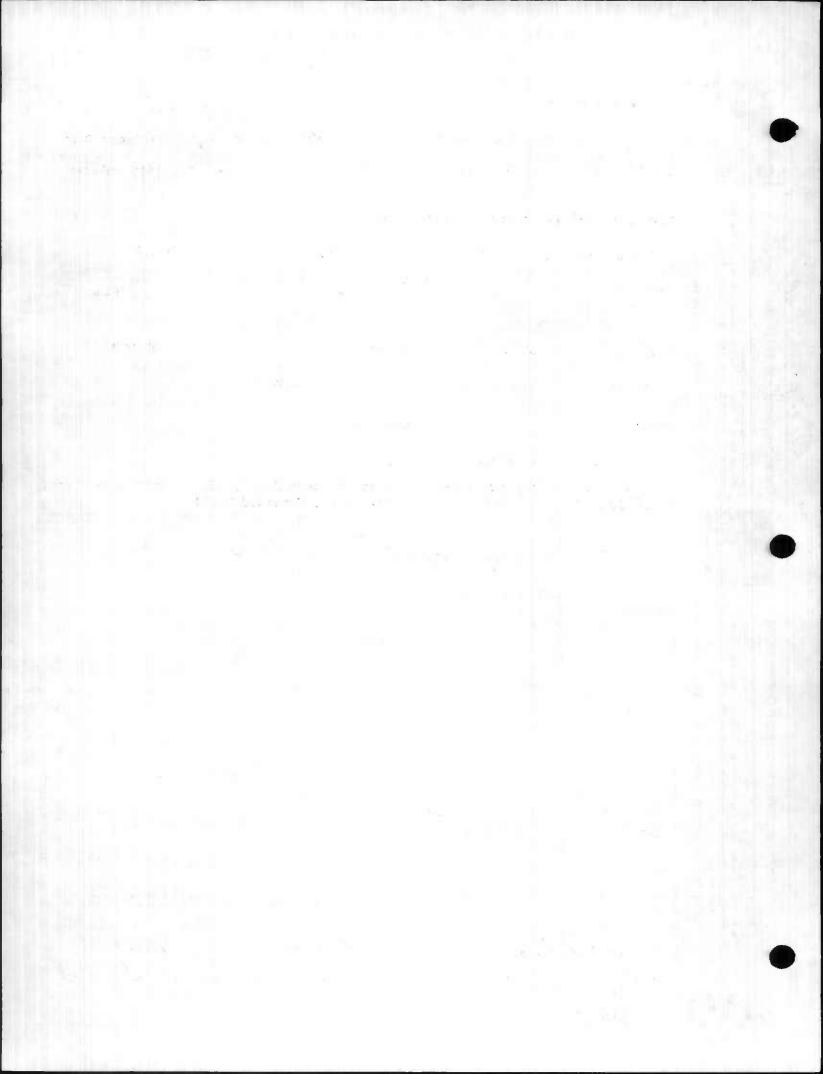
29d. Date signed (Month, Day, Year)

30. Name and agrees of person who completed cause of death (Item 23a) (Type, Print) Dalsana, ag 40

maryland General Hospita

31. Date tiled (Month, Day, Year) JAN 25 1999

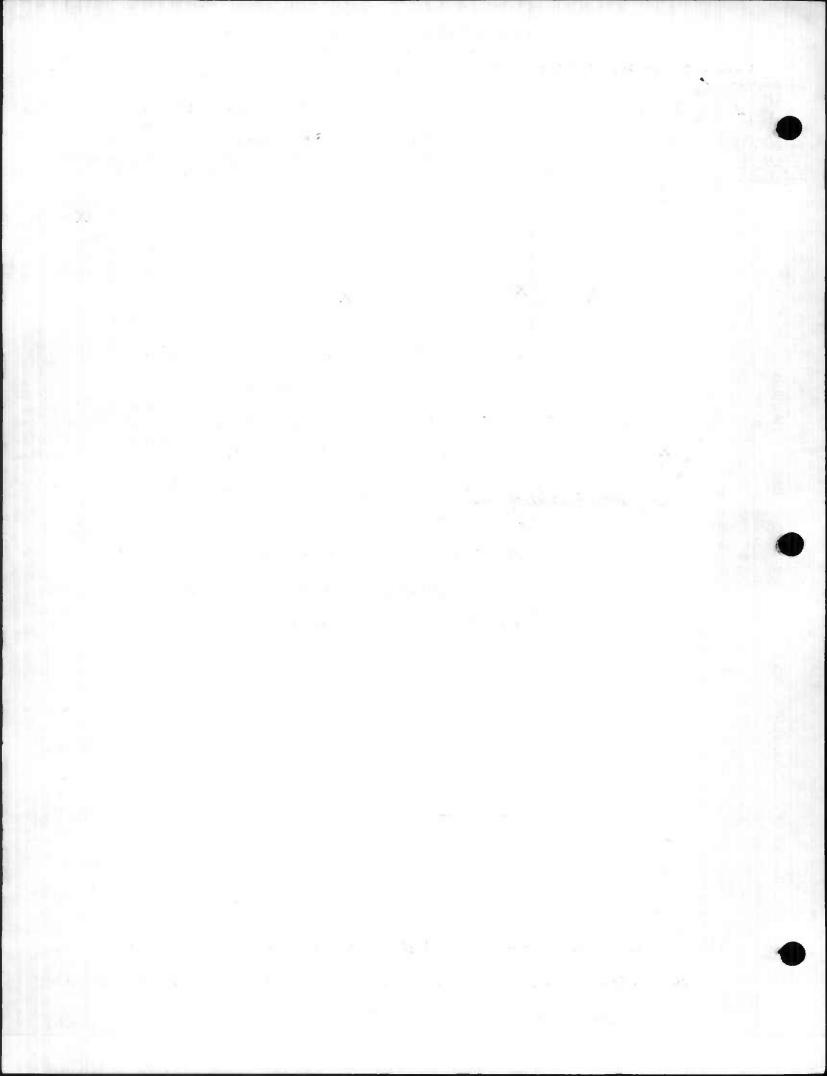
32 Begistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Exami		4a. Facility Nama (If not institution, giva street and number) 4b. City, Tov							or Location of Deat		ty of Death	(1)
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8	Funeral Director		5. Social Security Number 219 58 331 Usual Residence of Decede		Sex I⊠M 2□F	7. Age (In yr 47	s. last birthday, Yrs.	Months Days		in. OCT.1	, 1951	9. Birthp	lace (State or Foreign YLAND
	/lend		10a. Stata 10b. C			10c. (City, Town or L	ocation				1	0d. Insida City Limits
	a-f sh	tor	MD.	N/A			BAL	CIMORE					1 Yes 2 No
	or 28	Dire	10e. Street and Number					10f. Zip Code			10g. Citlzen o	What Coun	itry?
	5-0020 72 hours after death with the Marylend natural; or Items 23e or 28s-f show deal Exacilizer must be recitified at	<u>a</u>	1642 SHAD	YSID					218			. OF	Α.
21215-0020		by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Div		12. Was Dec Armed Fo 1 X Yas If Yes, Gir Yaar or D	orces? 2 No		Was Decedent of If Yes, specify Cub 1☐ Yes 2XNo		(Specify Yes or No erto Rican, etc.)		ice - Americ ack, White, ify: BLA	etc.
5-0	"natural",	eted	15. De	edent's Ed	ducation ada completed)	pleted) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of lifa. DO NOT usa ratired)			pation	vodrina	16b. Kind of	Business/inc	dustry
121	C 1 50	Completed	Elementary/Secondary (0		College (1-4or 5+)			'lifa. DO NOT usa ratired) CHOOL TEACHER			CCITOO	T CVC	STEM
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ary	2 should and Menis market	-	19e. Informent's Name/Reli		Type, Print)		19b. Maili	ng Address (Strea		Rural Route Numb		n, Stata, Zip	co2)1133
_	C - 8 -		LELIA M. N	EWKI	RK (DA	UGHTE	(R) 6 1	EVATT C	OURT F	RANDALLS	STOWN,	MARY	LAND
Baltimore,	0 80 = 5		20a. Method of Disposition 1 X Burial 2 □ Crame 4 □ Donation 5 □ Oth	ition 3 ⊑	Removal from	State GA	Placa of Dispo cematary, cre RRISO	psition (Nama of metory or other pla N FORES	1/22/9 T VET,	O Date CEM.			wn, StataBALTO
Balt	permit. Pa Departmen Important: any Injury once.		21. Signature of Foneral Sa	rvice Licer	Luga Luga	T. G			. GWYNN	FUNERA		E 212	215-6393
	_		23a. Part1. Enter the disaa shock, or heart failure	sa, or com	plications hat o	aused the de						10.,1	Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)		a. HY	Due to	(or as a conse			THY . BLEE	Dive		
	between d	Examiner	Sequentially list conditions	-	b. arr		(or as e conse	-	SINAL	. DLEE	DING	<u> </u>	
68760,	ficate be executed physician and as the burial-transit	edical Exa	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest	{	c. PG	RTAL		PERTE	NSION				
Box 6		Physician/Me		L	d								
P.O.	as thet tha de igned by the e be detached to	hys	Part II. Other significant co	nations c	ontributing to de	eath but not re	sulting in the u	ndarlying cause gi	iven in Part I.		Yes 2□ No		the cause of death?
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of Vital Records,	aw requii ss been s 2 should	Completed								24a. Was	an autopsy omned?	ava	ore autopsy findings ailable prior to mpletion of causa death?
Œ.	o - 6	E								10	Yes 20 No	10	Yes 2 No
Ita		Be	25. Was case referred to me examiner?	edical					26. Place of D	eath (Check only	ona)		
5	Physicien: this certific ral director,	2	1 ☐ Yes 2 ☑ No		Hospital:	npatient 🗳	ER/Outpatie	II SLI DOA		Home 5 ☐ Resi	idence 6 🗆 O	ther (Specif)	1)
UC.	ding P. h. Aftar t funera	io		ending		of Injury th, Dey Year)	28b. Time o Injury	Wo		28d. Describe	how injury occi	urred	
Division	or Attend fractor: in by the										ation (Street and Number or Rural Routa Number, or Town, Stata)		
٦	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one)	tifying Ph	niner: On the ba	best of my kr asis of exemin	owledge, death action and/or in	n occurred at the ti vestigation, in my	ime, date end ple oplnion, deeth oc	ce, end due to the curred et the time,	cause(s) and n dete end plece	nanner as st , end due to	eted. the cause(s)
	To the To the Comp	M	29b. Signature and title of co	artifier	. /			29c. Licen			29d. Date sign	ed (Month, I	Day, Yaar)
			D. K.	AL	tah	N.	1.0	PI	2555	>	Jan.	17.	1999
			30. Name and addrass of pe RAMIN ALTAHA	rson who	completed caus	e of death (Ite	om 23a) (Type,	Print) 5601 Well 1	RAVEN Bould	EVARD, BAH	TIMORE,	40 212	39-2995
	Sta Registr		RAMIN ALTAHA 31. Date filed (Month, Day, JAN	2 5 15	999 32. R	gistrar's Sign	gature 9.	Spork	2				

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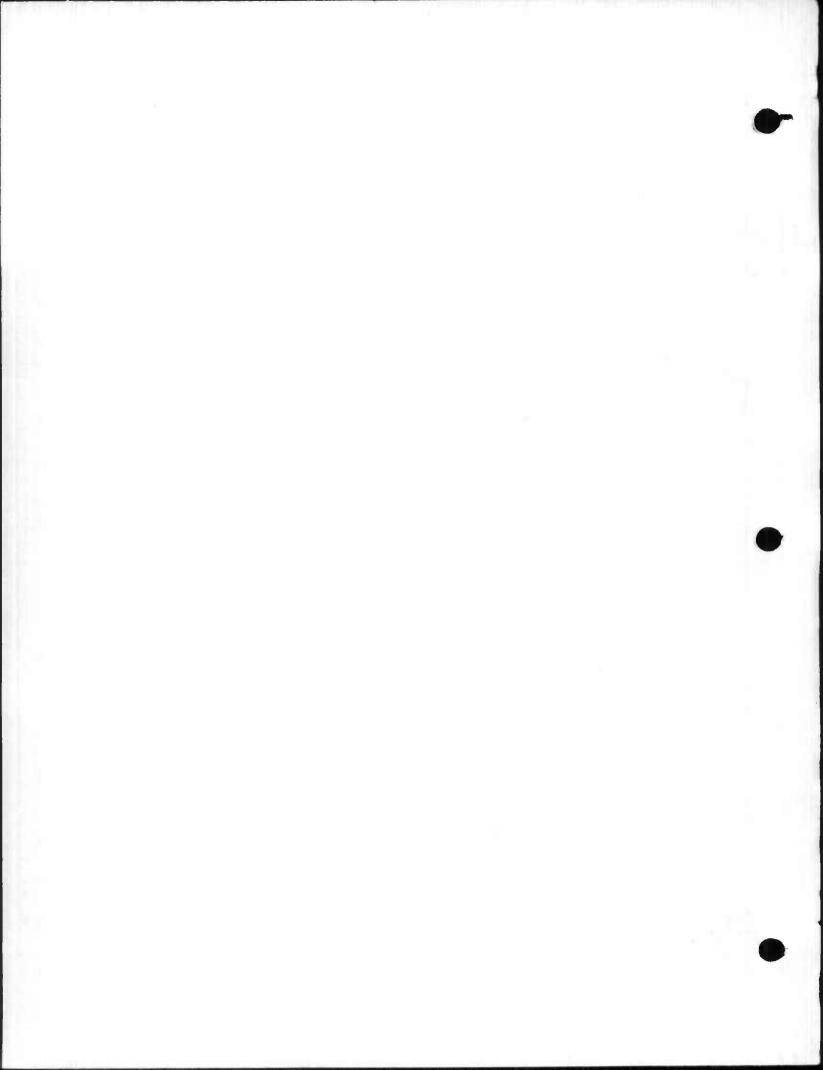
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STATE OF	MARYLAND	/ DEPARTMENT	OF HEALT	H AND	MENTAL	HYGIENE
	C	ERTIFICATE	OF DEA	HTA		REG NO

	1. DECEDENT'S NAME (First, Middle, Last) Trene Stuke	2. DATE OF DEATH DAY 1999 3. TIME OF DEATH 3. 45 A.						
	4. SOCIAL SECURITY NUMBER 5. SEX 1 S. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRE 2.15 - 40 - 0.0 44 1 M 2 F 92 YRS. 92 YRS. 92 YRS. 94. CITY TOWN OR LOCATION OF	3-22-1906 Country) K. Y						
STOR	FOR THE HOUSE N. H. Catonsulle RESIDENCE OF DECEDENT So. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF Catonsulle	DEATH Sc. COUNTY OF DEATH Baltimore						
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Baltimore Catons ville	10d. INSIDE CITY LIMITS? 1 \square YES 2 \square No						
FUNERAL	3/5 Ingleside Avenue 100. STREET AND NUMBER 100. ZIP CODE 2/2 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED 13. WAS DECEMBENT OF HIS	.0.7/						
B	1 Never Married 2 Married 3 Wildowed 4 Divorced Never Married 2 Married FORCES? 1 VES 2 NO If yes, specify cuban, Married If yes 2 NO If yes 3 NO If yes 4 NO If yes 5 NO If yes 6 NO If yes 8 NO If yes 9 NO If ye							
PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) WWC-College (1-4 or 5+) Dome SAC	Private Homes						
BE COMPL	17. EATHER'S NAME (First, Middle, Last) Reginald Rankin's Mamis	NAME (First, Middle, Malden Surname) Rankins						
TO B	19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Paul Barbara Adgers Great Niece 3819 Paul Uleu 20a, METHOD OF DISPOSITION 20a, METHOD OF DISPOSITION	Avenue Balto, red 212						
examiner must	Buriet 2 Cremation 3 Removal from State Campions crematory or other place Campions crematory							
medical exam	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, s	Wabash Balto, red 2121						
event, the	shock, Dr heart feliure. List pnly Dne ceuse Dn each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) S. JERMAN AL UTER INF CAMP DUE TO (OR AS A CONSEQUENCE OF): B. DUE TO (OR AS A CONSEQUENCE OF):	Interval Betwee						
ERTIFIC	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
MEDICAL CE	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given	PERFORMED? 1 YES 2 NO COMPLETION DF CAUSE DF DEATH?						
97	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAGE 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	IN .						
PHYSICIAN	EXAMINER? 1 YES 2 MO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Moraing Home 5 Residence	e 6 ☐ Other (Specify)						
marked, BY PH	27. MANNER OF DEATH 1 Astural 5 Pending 2 Accident Investigation 288. DATE OF INJURY (Month, Day, Year) 288. TIME OF INJURY WORK? 1 YES 2 NO	26d. DEȘCRIBE HOW INJURY OCCURED						
ETED	3 Suicide 6 Could not be detarmined 25e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Roi City or Town, State)							
MPORTANT: IF ITS	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and done) 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time.							
TO BE	296. SIGNATURE AND TITLE OF CENTIFIER 296. LICENSE N 1-1 45 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	1931 DATE SIGNED (MONTH, Day, Year) Panuary 18 1999 HS AVE. BALLHAE, H.) 2120						
	Deborah I Pierce 7220 Park Heigh	to AVE BOLLINE HIDZINI						

DHMH-16 Rev 1/89



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath Month 40 AM Doris Taylor January 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BA GIMORE CITY MARYLAND GENERAL HUSPITAL Baltimore City 8. Data of Birth (Month, Dey, Nov. 7, 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) unknown 7. Age (In vrs. lest birthday) 1□M 2□F Deys 219-32-1887 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Baltimore City Baltimore 1 D∜es 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 501 West Franklin Street 21201 U.S.A. 12. Wes Decedant Evar in U.S. Armed Forcas? unknown 1 ∐Yes. 2 ∐No It Yes, Give Yaer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) unknown unknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) unknown 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cramatory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 5 ₩Other (Specify)in state 21. Signature of Funeral Service Licensee Ronald S. Wade, ²² State Anatomy Board, 655 W. Baltimore Street Director Baltimore, Maryland 21201 and. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, lock, or heert feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) bue to (or es a consequence of): Encephalopath Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest erebrovascular Accident Pert II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings aveileble prior to completion of ceusa of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menper of Death 28e. Dete of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. Records, Division of Vital

ettending physiclan for use es the burie been signed by the should be detach page 2 After this within 24 hours aftar death.

To the Funeral Director: After this
completely filled in by the funeral of To the Hospital

Physician

/Medical

Examiner

Funeral

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28a-f show

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Items 23a

"natural", or

Peges 1 and 2 should be filed within nent of Haalth and Mantal Hygiena.

Department of Health and Important: If Item 27 is many Injury or other traum

Physician

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> the buriel-trensit and

Physician/Medical Examiner

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Certification:

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4 ☐ Homicide

29a. Certifier

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traumatic event, the Medical Examiner numbe notified at

the Maryland

State Registrar

31. Dete filed (Month, Dey, Yeer)

29b. Signatura and title of certifian

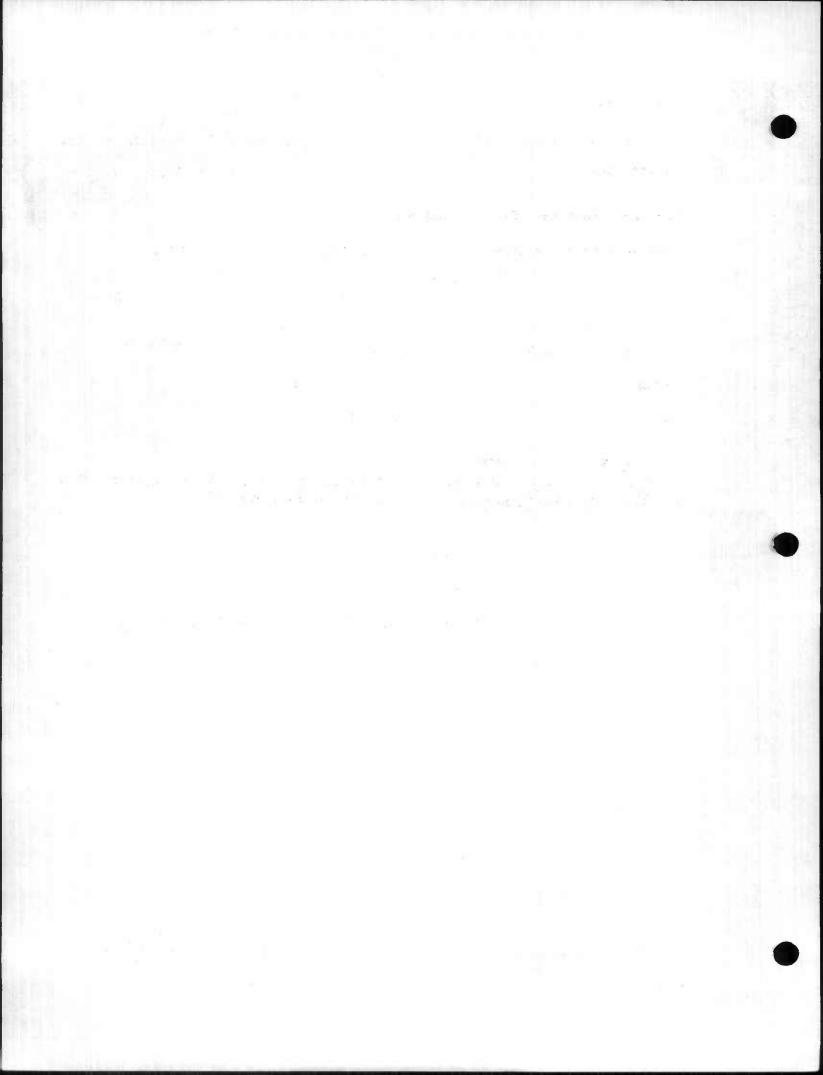
Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

29c. License number

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceusa(s) end manner stated. 29d. Data signed (Month, Day, Year)

Maryland General Hospita



1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Donald Francis Vickerman January 17, 1999 ation of Death Dic, County of Death /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) Sept. 15, 1923 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days NE M 2□ F 75 475-16-5278 Director Usual Residence of Decedent the Maryland 10a. Stata 10c. City, Town or Location 10b. County 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, tre Medical Examiner must be notified at Maryland Director Worchester Pocomoke 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2148 Worchester Highway 21851 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Giva 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White py 3 ☐ Widowed 4 ☐ Divorced Yaar or Dates: 1943-46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "neny injury or other treasment. Elementary/Secondary (0-12) College (1-4or 5+) Donald Vickeman 12 0 UNKNOWN UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles C. Vickerman Alice Fremgen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Vickerman/wife 2148 Worchester Highway, Pocomoke, Maryland 21851 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Füneral Service Licenses 22. Name and Address of Facility Ronald S. Wade, Director State Anatomy Board, 655 W. Baltimore Street aler Baltimore, Maryland 21201 23a. Pat I. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Cause (Final Dreumonia disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and bunal-transit daath certificata be axacuted

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as a consequence 10

7 23b. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

1 Yes 2 No 3 Probably 4 ₽ Unknown

24a. Was an autopsy

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

3. Time of Death

1103

10d. Insida City Limits

1 ☐ Yes 2 ☐ No

9. Birthplace (State or Foreign

Lowa Iowa

1□Yas 2₽No

1 ☐ Yas 2 ☐ No

25. Was casa referred to medical examiner? 1 Yes 2 DING 27. Manner of Death

29b. Signature agentille of cequities

31. Data filed (Month, Day, Year)

1 PNatural

2 Accident

3 ☐ Sulcide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending Investigation

1 1 Inpatient 2 □ ER/Outpatient 3 □ DOA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death

> Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28b. Time of 28c. Injury at Work? 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one)

12 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29c, Licansa number

29d. Date signed (Month, Day, Year)

30. Name dress of person who completed cause of death (Item 23a) (Type, Print) 3 B1-Stute

State Registrar

physician s the bunal

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Mospital or Attendi 24 hours after death Funeral Director: A

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Certification:

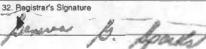
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Box 68760

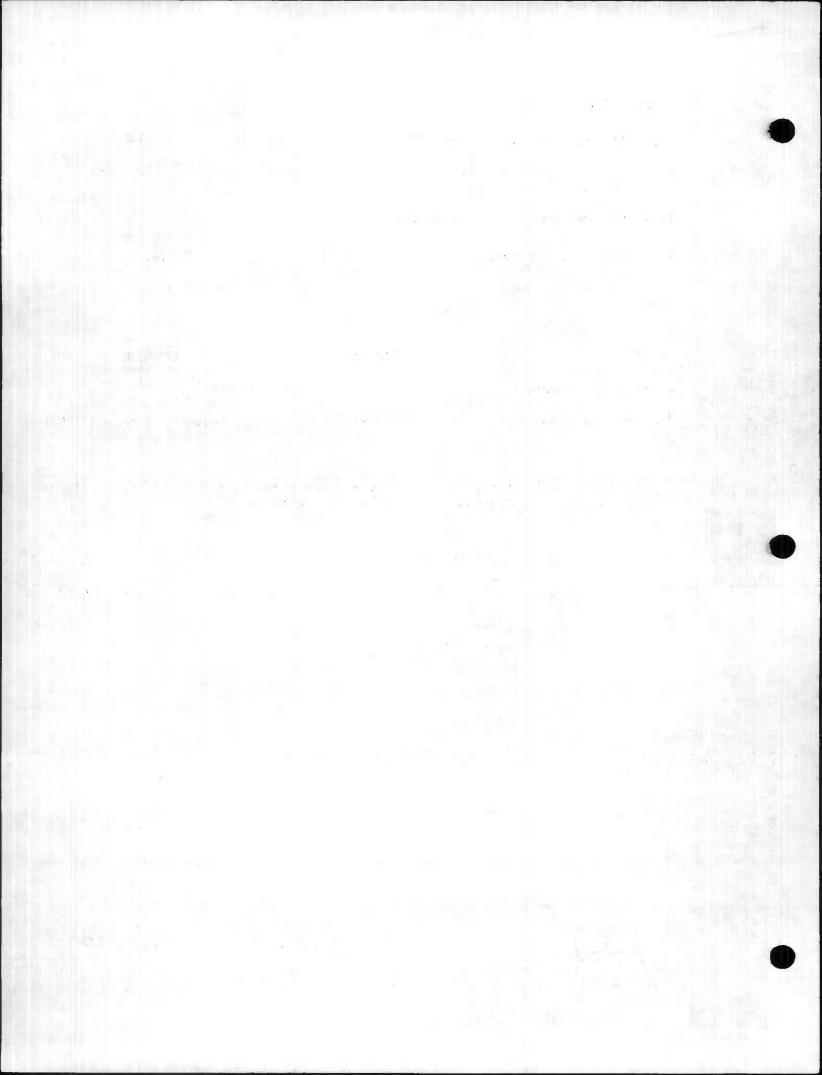
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Division of Vital Records.

6 Could not be determined

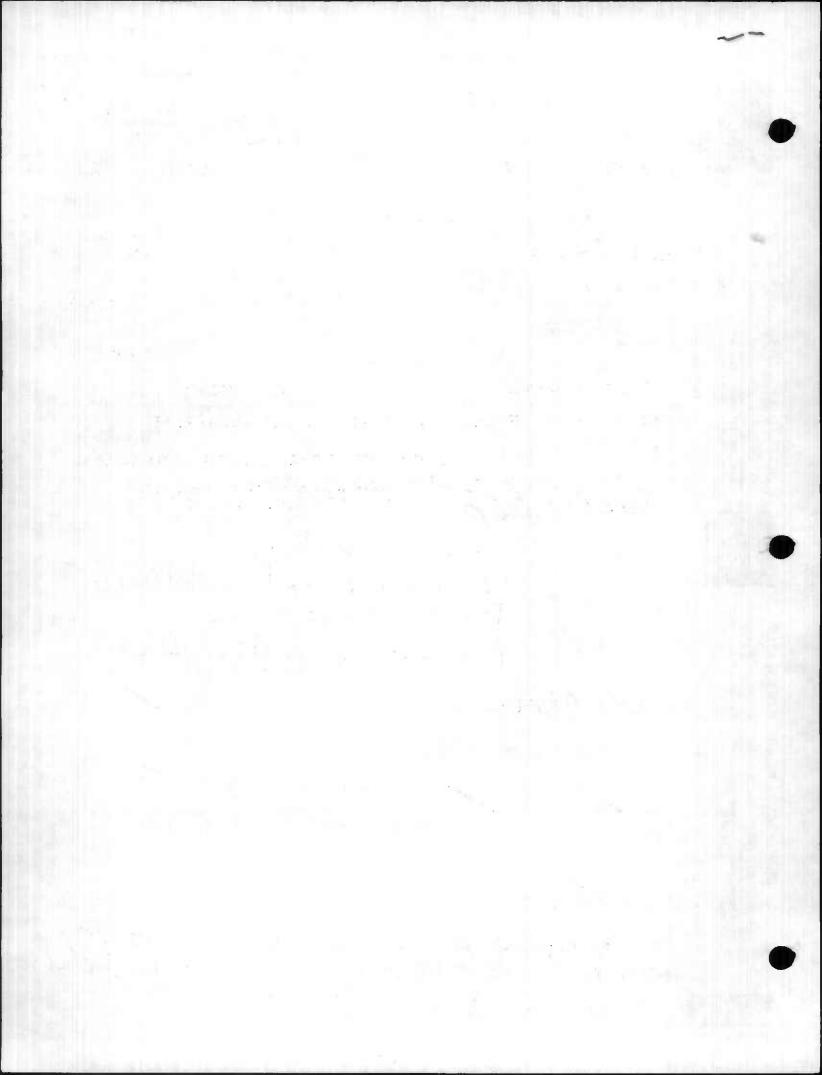


DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of D636 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month WALKER **Physician** 22 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BON SECOUR HOSPITAL N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth Wonth Dev Years 9-12-1937 9. Birthplace (Stete or Foreign Country) **Funeral** Months Days 1□M 200 F Hours 245-50-3145 61 Director Usuai Residence of Decedent the Merylend 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r 28a-f show show 1 Yes 2 □ No N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Peges 1 end 2 should be filed within 72 hours after death with nent of Health end Mental Hygiene.
Int: If Itam 27 is marked other than "natural", or Hems 23s or inty or other traumatic evant, the Mexical Experience must be nearly or other traumatic evant. U.S.A. 21223 128 S. CAREY STREET Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indien 11. Maritel Status Biack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: AFR. AMERICAN þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 0 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be SYLVESTER KENNEDY SUSIE JACKSON 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) LAWRENCE WALKER (SPOUSE) 128 S CAREY ST. BALTIMORE MD 21223 20e. Method of Disposition 20b. Piace of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremation 3 Remove from Stete permit. Pege Department of fmportant: If any injury or once. WESTERN STAR CEMETERY 1/27/1999 4 ☐ Donetion 5 ☐ Other (Specify) CATONSVILLE MD 21. Signature of Funeral Service Licensee CECIL 22. Name end Address of Fecility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician end s the burial-transit the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai ettanding ph for use es t signed by the e 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown P 24b. Were autopsy tindings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed? s certificate hes birector, page 2 s No 1 ☐ Yes 1 TVes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menne of Deeth 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: After 1 Natural 5 Pending investigation Injury after deeth.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide • Funeral DI 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) end manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifier D 120 " of deeth (Item 2 ta) (Type, A rint) OLO 32. Register's Signature 31. Date filed (Morgh, Day, Year! State 25 Registrar **DHMH 16 Rev 6/95**

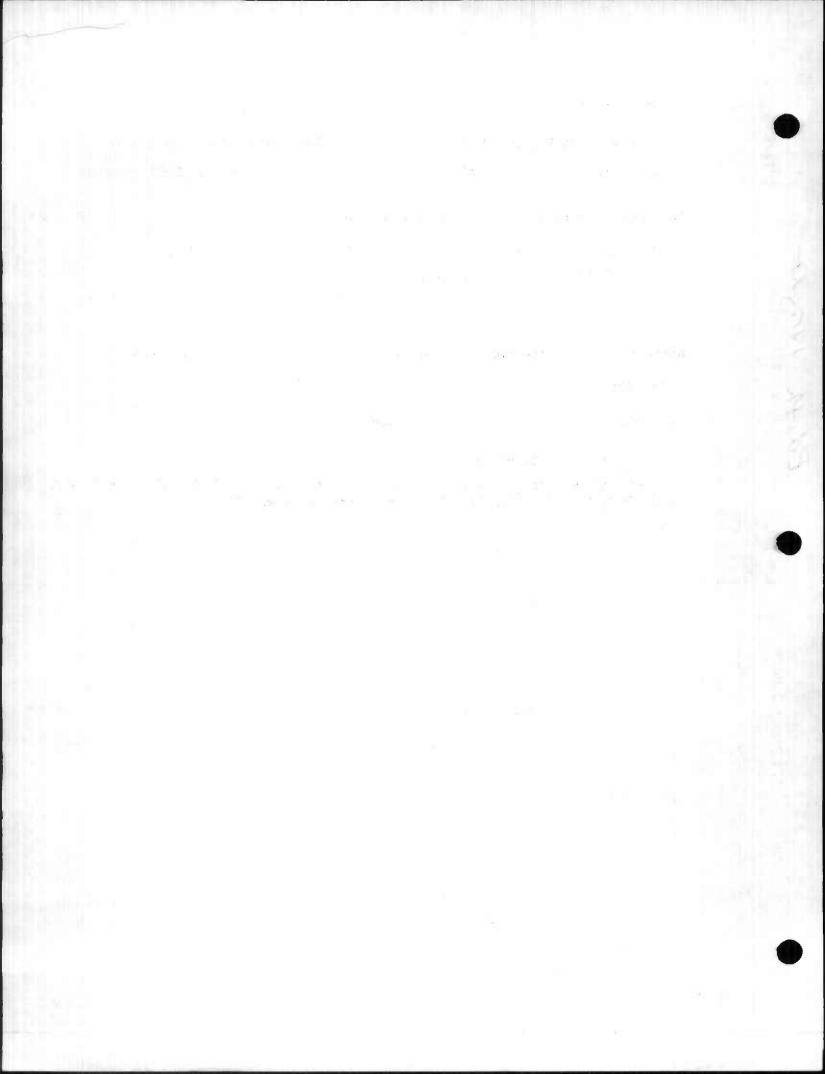


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth **Physician** Month Yaar 41:40 am Edith Wright Januar 1999 /Medical 4a. Facility Nama (If not institution, giva straet and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Forest Haven Nursing Home Baltimore Baltimore County 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 6. Sax Birthplaca (Stata or Foreign Country)
 UNKNOWN **Funeral** 7. Aga (In yrs. last birthday) 1□M 2₽F Days 90 Yrs. Director 178-12-3926 10a. Stata 10b. County "natural", or items 23s or 28s-f show 10c. City. Town or Location 10d. Insida City Limits Director Maryland 1 Yas 2 No Baltimore Baltimore County the 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 315 Ingleside Avenue 21228 U.S.A. Funerai 12. Was Dacedant Evar in U,S. Armed Forcas?unknown 1 □ Yas 2 □ No It Yas, Giva Yaar or Datas: 11. Marital Status unknown 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black White atc 1 Navar Married 2 Married 1 ☐ Yas 2 ➡ No Completed by 3 Widowad 4 Divorced Specify: Black traumatic event, the Medical 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Hygiene. marked other than Collaga (1-4or 5+) unknown unknown unknown unknown 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumeme) Be Pages 1 and 2 should be 1 unknown unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 60 If Item 27 i unknown unknown 20b. Placa of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 □Donation 5 ☑Othar (Spacify) in state Ronald S. 22. Nama and Address of Facility
State Anatomy Board, 655 W. Baltimore Street 21. Signature of Funeral Se Wade, Director 10110 Baltimore, Maryland 21201 Part I. Entar tha diseasa, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Physiclan NTEROCOOCCAC Immediata Cause (Finel disaasa or condition rasulting in daath) /Medical Examiner Dua to (or es e consequence of): Examiner bunal-transit Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initieted events rasulting in death) Last pue Dua to (or es e consequance of) Box 68760, Physician/Medicai Dua to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Records, þ Completed 24a. Was an autopsy 24b. Wara autopsy findings available prior to completion of cause of death? page 2 s certificate 1 Yas 2 No 1 Yes 2 No Division of Vital Hospital or Attanding Physician: 25. Was casa rafarred to medical axaminer?
1 Yas 2(D) No funeral director. Be 26. Place of Daath (Check only one) Hospital: Certification: To Othar: Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatiant 3 DOA this 27. Manger of Daath 28e. Deta of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? After 1 ☑ Natural 2 ☐ Accident 5 Panding To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A Investigation 1 Yas 2 No 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicida 29a. Cartifian Cartifying Physician: To tha bast of my knowledge, deeth occurred at tha time, data and place, and due to the cause(s) and mennar as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who completed causa of deeth (Itam 23a) (Type, Print) 1220 31. Deta filed (Month, Dey, Year)

Registrar **DHMH 16 Rev 6/95**

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Q Amended#23a Pt1A, B PER Phy G767 1/25/9 Dertificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death Month 3. Time of Death Year WILEY MILDRED JANUARY OII 1999 :20 AM 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore HOPKINS Ita If Under 24 Hrs. If Under 1 Vaar 6. Sex Aga (In yas, last birthda) 9. Birthplace (State or Foreign Days 56 Months 1 M 200 F Usuat Rasidence of Dacedent 10d. Inside City Limits 10a. State City, Town or Location timore 1 Yes 2 No 10f Zip Code 10e. Street and Number 10g. Citizen of What Country? ad Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Yas 2 No If Yas, Giva Year or Dates: 1 Mever Married 2 Married 1 Yas 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working L. life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 17 Father's Nama (First, Middla, Last, 18. Mothar's Nema /First, Middle, Maiden Surnamel 19a, Informant's Name/Ralationship 20.110, MD. SISTER didi 20b. Place of Disposition (Nama of cemetary, crematory or other p 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Sarvice Licensaa Approximata Interval Between Onset and Death 23a. Part1. Griar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. SEVERE THROMBOCYTOPENIA 2 DAYS Immediata Causa (Final diseasa or condition rasulting in death) HEPATIC FALL 12015 3 Years 25

Physician /Medical Examiner

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Be Completed by

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After this death.

To the Hospital or Attendi within 24 hours aftar death. To the Funeral Director: A completaly filled in by the fi

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ahow Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" — "nat

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contributing to	death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of dea

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JANUARY 12,1999

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Part II. Other eignificant conditions co	ontributing to death but not resulting in	n tha underlying causa giv	en in Part I.	23b. Did tobacco use co	antribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
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2 D ACCIDANT	stigetion	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work?		8d. Dascribe how inj	jury occurred	
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29a. Certifier (Check only one)		y knowledge, deeth occurred et the time, date and plece, an iminetion and/or investigation, in my opinion, daeth occurred	
29b. Signature an	d title of certifiar	29c. License number	29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) HOPKINS JUHNS HOSPITAL

31. Data filed (Month, Day, Year) 32. Registrar's Signetura JAN 25

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Registrar **DHMH 16 Rev 6/95**

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Veer 4b. City, Town, or Location of Death 4c. County of Death 0 (If not institution, give street end number) Lorien Nursing Home Columbia, MD Howard 5. Sociel Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Deys 174-09-2730 XXX M 2 F 83 Yrs April 18, 1915 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Columbia, Maryland 1 ☐ Yes ZXXNo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 21044 6334 Cedar Lane United States Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 12 No If Yes, Give 1 ☐ Yes 2 XXX White Specify: Specify: 3 Widowed 4 ☐ Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Auto. parts Distr. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John M. Wilson Laura Hunter 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Marnie Isabella / Daughter 8965 B. Early April Way Columbia MD 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location · City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3√☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Castle View Memorial Gardens Jan. 27,1999 New Castle, PA 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22. Name end Address of Fecility Charles L. Stevens Funeral Home, 21230 1501 East Fort Avenue, Baltimore Maryland 23e. Pert1. Enter the disease, or complications that based in deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death tmmediate Ceuse (Finel 0015 disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequença ot): Due to (or es e consequençe of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Arkinson Son 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: Suursing Home 5 Residence 6 Other (Specify) 1□ Yes SENO 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - Al home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide

Box 68760 P.O. Records. **Physician**

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23s or 28s-f show on Medical Examiner must be notified at

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permit. Peges 1 end 2 should be filed wit Department of Health end Mental Hygiens Important: If Item 27 is marked other the any Injury or other traumatic event, the PARS.

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signed by t Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificaletely filled in by the funeral director. To the Hosp within 24 hor To the Funs completely fi

Registrar

DHMH 16 Rev 6/95

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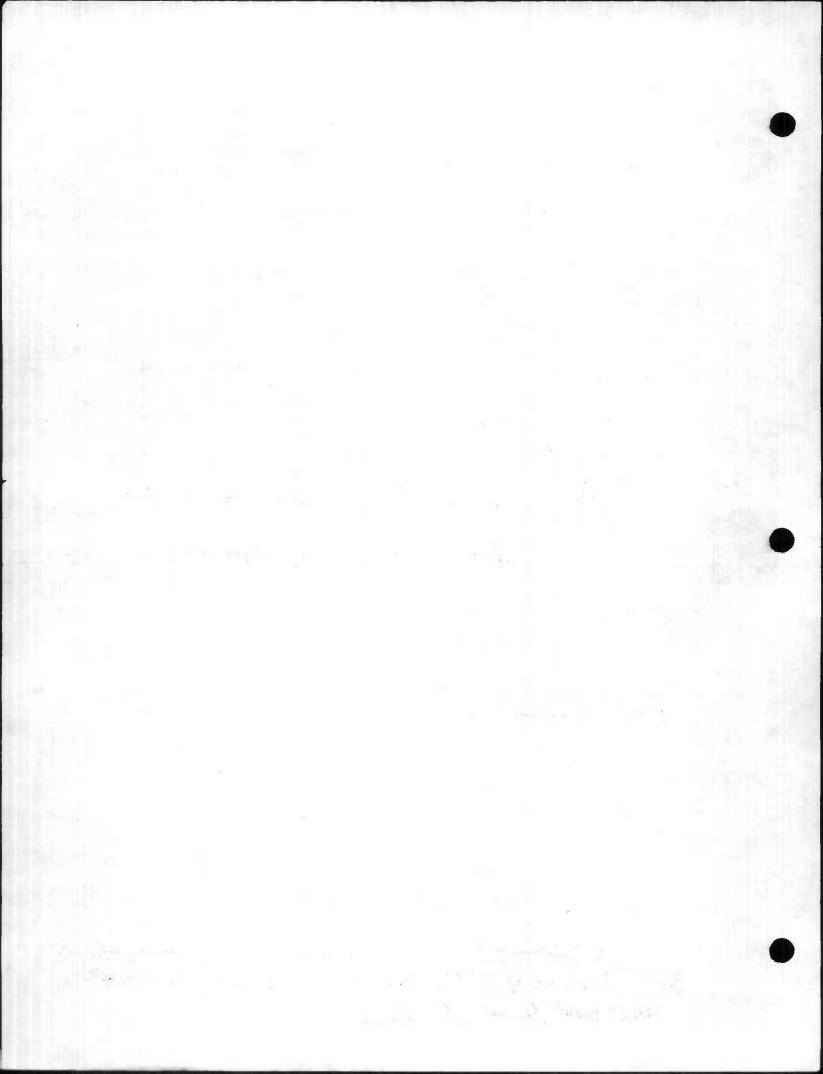
rson who completed cause of deeth (Item 23a) (Type, Print) 32. Registrer's Signeture

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated.

29c. License number

29d, Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) 2. Data of Daath Walker Sandra 1999 13.21 January 18 4a Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE Bayview HOSPITAL If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 6. Sax Days Hours 1 M 2 F Yrs 219-38-2246 56 JAN. 10,1943 MARYLAND Usual Rasidence of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits MARYLAND BALTIMORE 1 □X as 2 □ No N/A 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number 4633 CLAREWAY 21213 U.S.A. 12. Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 11. Maritaf Status 1 Yas 2 No If Yas, Giva 1 Nevar Married 3 Married 1 ☐ Yas 2√2 No SpecifAFRO-AMERICAN 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12TH N/A SEAMTRESS LONDON FOG 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) LOUENTHAL JOHNSON GLADYS PARKER 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Ratationship (Type, Print) 5301 IOUCH RAVEN BLVD. BALTO, MD. 21239 of Disposition (Name of Disposition (Name of Disposition (Name of Disposition)) DEBORAH ADAMS / SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition XBurial 2 Cramation 3 Ramoval from State JAN. 22, 1999 4 ☐ Donation 5 ☐ Othar (Specify) LOUDON PARK CEMETERY 22. Nama and Addrass of Facility CALVIN B. SCRUGGS FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the other Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death Immediate Causa (Final Intracerebral Hemorrhage One day diseese or condition resulting in death) Due to (or es e consequence of): Hupertension Five years Saquantially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disaasa or Injury thet initiated events rasulting in daath) Last Dua to (or as a consequance of): Dua to (or as a consaguance of): Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an eutopsy 1 ☐ Yes 2 No 1 Yes 2 No 26. Piaca of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Inpatiant 2 □ ER/Outpetient 3 □ DOA 28b. Time of 28d. Describe how injury occurred

P.O. Box 68760, 2 det signed t Division of Vital Records. page 2 s has or Attending Physician: funeral director.

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Physician

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r than "naturel", or items 23s or 28s-f show the Madical Exercines must be notified at

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permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If item 27 is marked other th eny injury or other traumatic event, the once.

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Place of fnjury - At homa, farm, straat, factory, office bullding, atc. (Specify)

28c. injury et Work?

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as steted.

2 Medical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29c. Licansa number

29b. Signatura and titla of certifian Wh, M.D, Ph.D., Resident

29d. Data signed (Month, Day, Year) Jamary 18, 1999

30. Nama and addrass of person who complated causa of death (Hem 23a) (Type, Print).

Justina Wu, Johns Hopkins Bayurus Medical Center, 4940 Eastern Avenue, Baltimore,

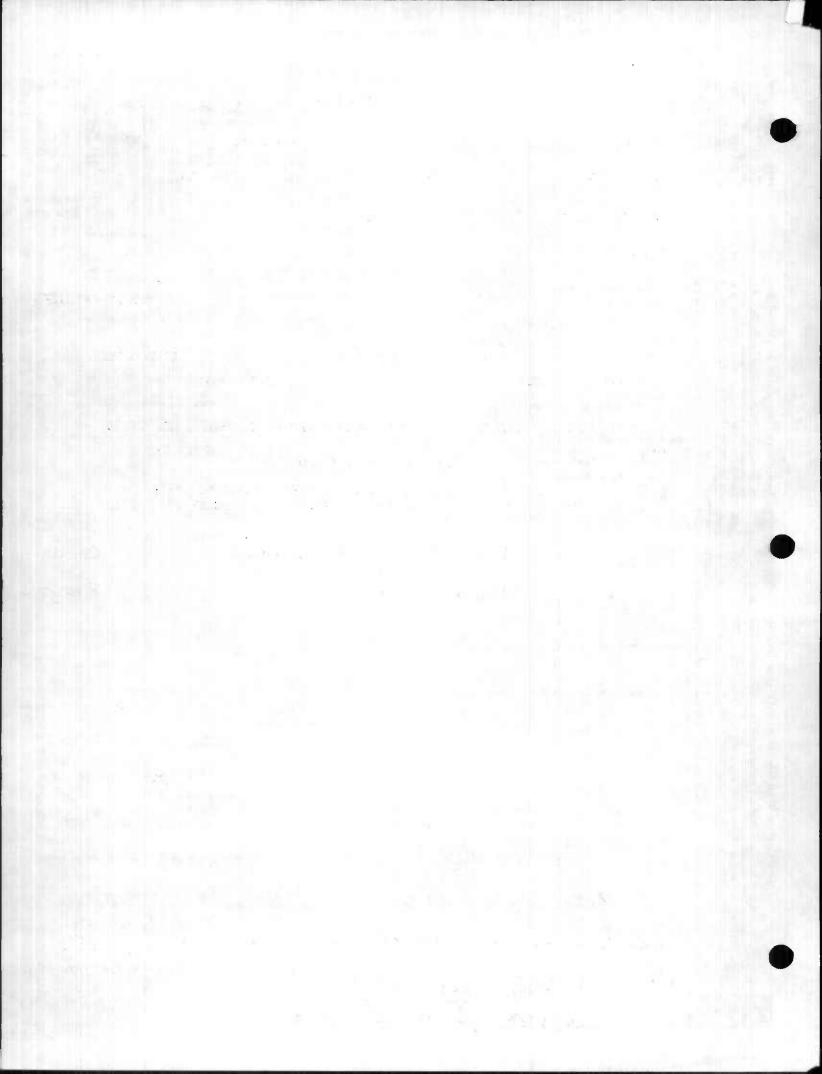
Maryland 21224-2780

Registrar

(Month, Day, Year)

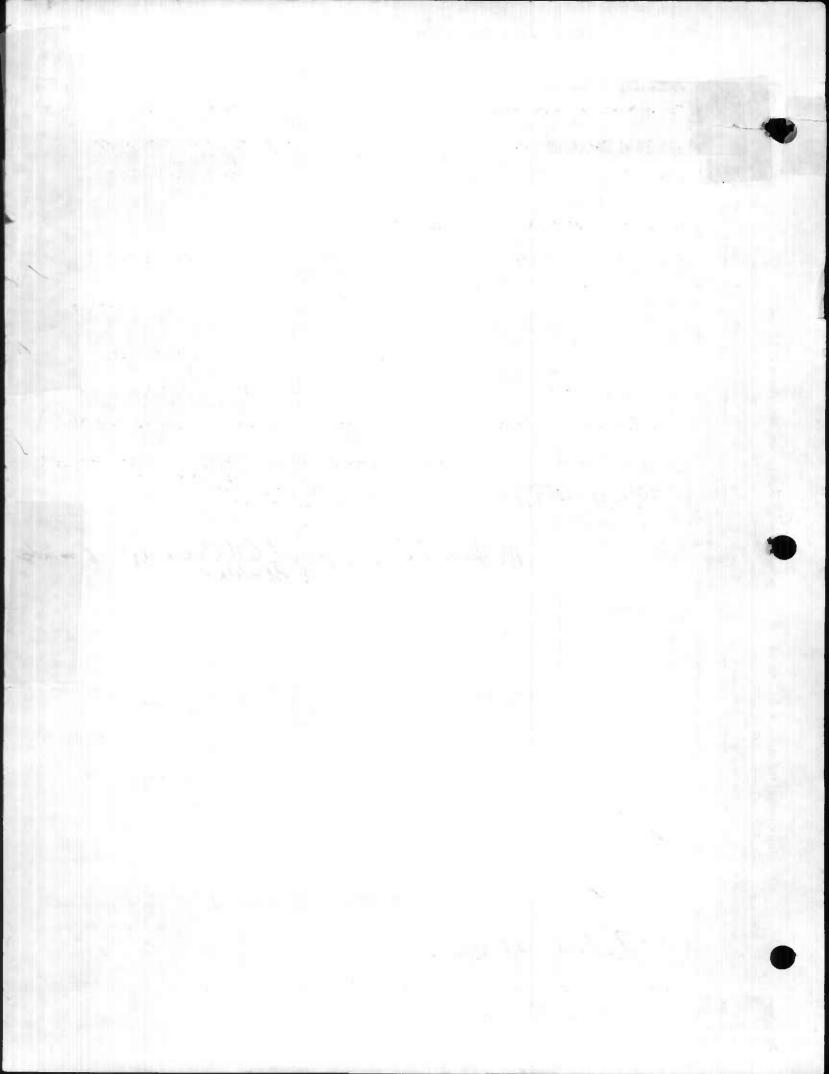
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No: 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month January 12, 1999 Danny Dean 6:43 AM Austin 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring 14215 Georgia Avenue, #201 Montgomery | Months | Days | Hours | Min. | Sept. 17, 1965 | North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 12 M 2 F 33 220-80-9119 Usual Rasidence of Deceden 10a, Stata 10b. Counts 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 1 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 14215 Georgia Avenue, #201 20906 USA 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, apecify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent'a Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working tifa. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Private 12 18 Mother's Name (First Middle Maiden Sumama) 17. Father's Nama (First, Middle, Last) Jo Ann Rivenbark Carl Austin 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant'a Name/Ralationship (Type, Print) 14215 Georgia Avenue, #201, Silver Spring, MD 20906 Mary Murphy Austin (wife) 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other placa) 20c. Location - City or Town, State Data 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State 1/14/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signature of Funaral Service Licensee Home, Inc. Silver Spring, MD 20901 23a. Part I there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, show for heart failura. List only one cause on each line. Approximata Interval Batween Onsat and Death Immediate Cause (Finel disaasa or condition rasulting in daath) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

20 No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year)

1 Yas

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify)

26. Placa of Deeth (Check only ona)

1 Yas 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-4 show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertial Hyglene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Examinations.

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

Director

Funeral

Aq

Completed

8

Examiner Physician/Medical þ Completed Be 10

25. Was casa referred to medical examiner?

29b. Signature and title of certifier

tatucia 30 Name and address of person who comple

5 Pending investigation

6 Could not be

1□ Yas 2No

27. Manger of Death

1 Netural

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

atricia

the ettending physician and hed for use as the burial-transit signed by to peen page 2 s has certificata this Certification:

certificate be To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After thi completaly filled in by the funeral

State Registrar

edicai

31. Data filed (Month, Day, Year)

28a. Data of Injury (Month, Day Year)

(Item 23a) (Type, Print)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At homa, farm, atreet, factory, office building, etc. (Specify)

28b. Time of

28c. Injury al Work?

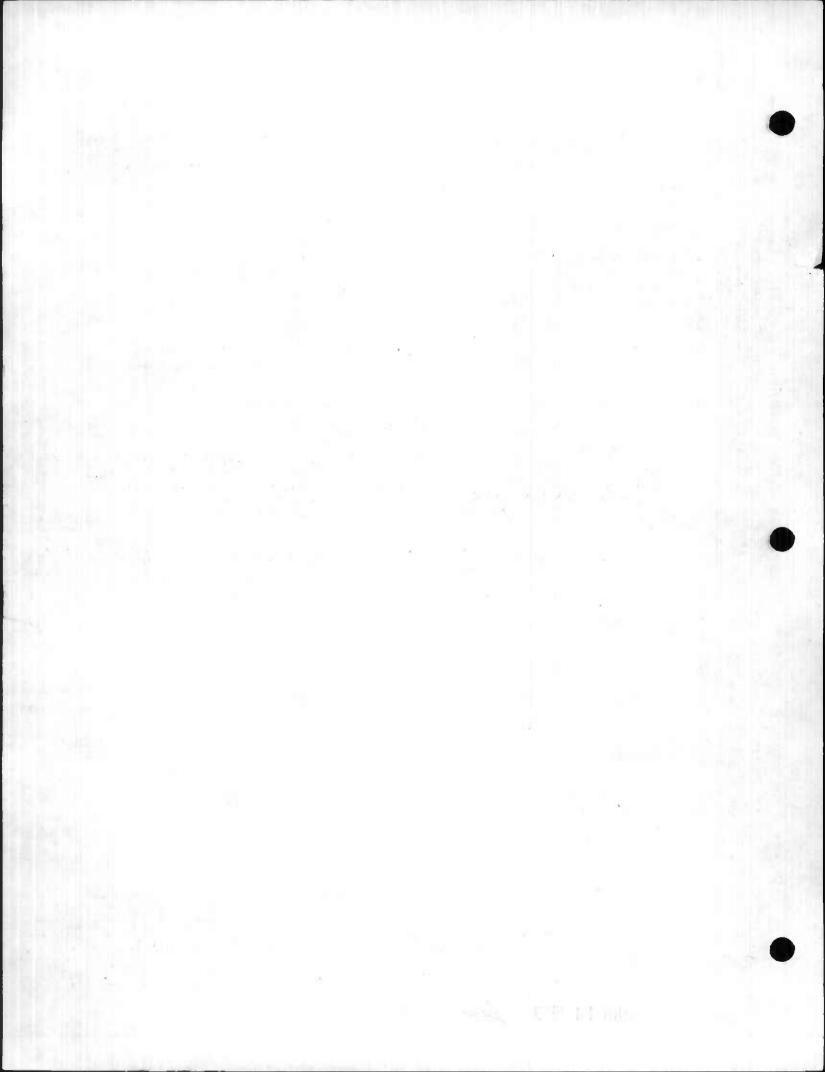
1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mennar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

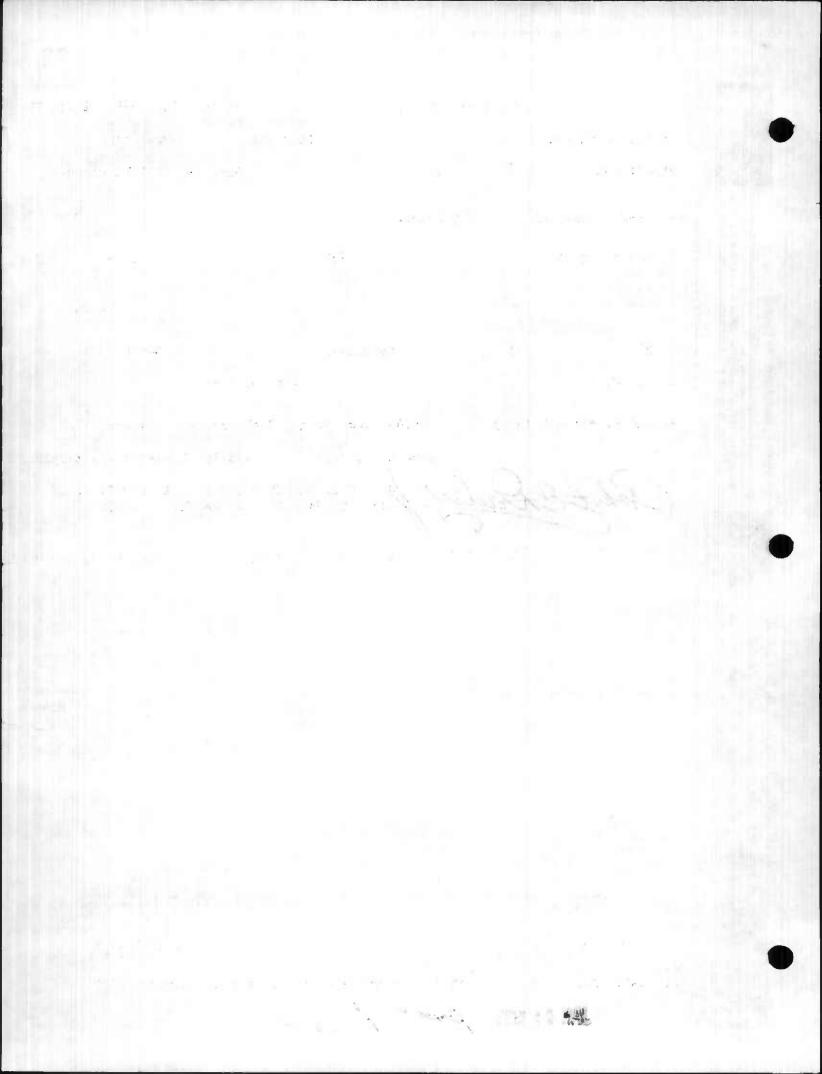
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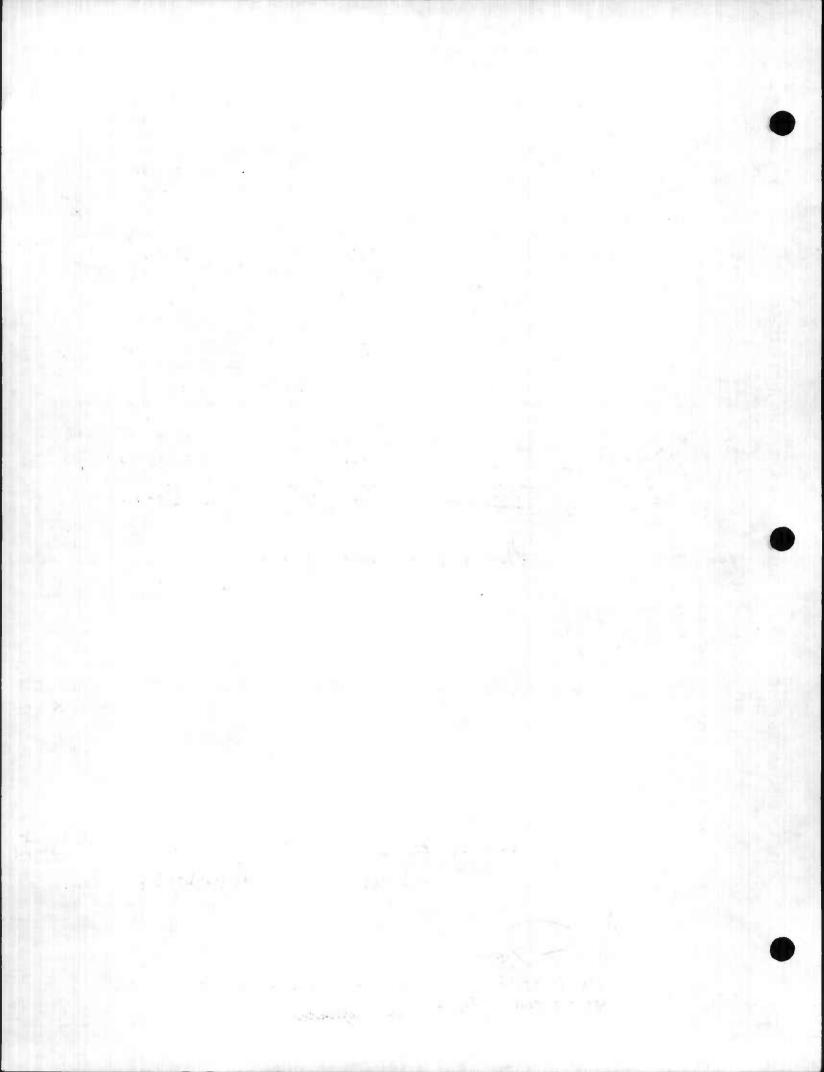
State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** RETA IONE ALBAUGH 1, 1999 January 12:34 PM /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 5 Locust Street Thurmont Frederick 8. Date of Birth (Month, Day, Year)
Dec. 29, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days Months Hours 212-74-3988 97 1901 Maryland Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. Stete 10d Inside City Limits 10b. County r than "natural", or items 23s or 28s-f show the Medical Exampler must be notified at Yes 2 No Director Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 Locust Street 21788 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Maritel Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or itee iny or other traumetic event, the Medical Example. 1 Yes ZN No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify þ 3 □ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surneme) Be Calvin C. Fogle Elfie M. Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Ronald L. Albaugh (Son) 8949 Rocky Ridge, Rocky Ridge, Maryland 21778 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Fairmont, Cemetery 1/5/99 Libertytown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST., THURMONT, MD 21788 of enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Between Onset and Death Physician Immediate Cause (Final diseasa or condition resulting In death) /Medical untroca Carcinoma Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): that the death certificate be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of) (5) 980 0 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed page 2 s 2 1 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation + Datural after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicide 24 hours a 29a. Certifier stifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. (Check only one) completely within 2 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 0 arr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Austin Pearre Jr., MD 300 West Ninth Street, Frederick, Maryland 21701 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature State

Registrar



State of Maryland / Department of Health and Mental Hygiene 9 0 1 5 2 3

						Cei	rtificate	e of	Death			Reg. No.) U	1767	
		1. Decedent's Name (First,	Viddle, La	st)							2. Date of De	ath		3. Time of Death	
и	Physician	Earl Edwa	rd	Burke,	Ir						JANUA	RY 9, 1	Year 999	0237 AM	1
	/Medical Examiner	4a Facility Name (If not inst SHOCK TRAUM	itution, giv	e street and nu						wn, or Lo	ocation of Deatl		ity of Death		
_					- A	1 . 1 . 1 . 1	W Heder	4 Vons	If Under	24 Hm			1		
	Funeral Director	5. Social Security Number 220–17–6388	6. S	Sex IDX,M 2□ F	7. Age (In yn	s. last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bir (Month, Da Februa	th y, <i>Year</i>) ryll,19	9. Birth	placa <i>(State or Fore</i> ntry) Iaryland	ign
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	vith the Me r or 28a-f a be notified	10e. Street and Number						Code			10g. Citizen of What Country			ntry?	
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Maryland 21215-0020	within 72 hours after death with the Menyland ene. than "natural", or items 23s or 28s-f show the Medical Energies must be modified a empleted by Funeral Director	1 X Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive		Armed Find Yes If Yes, Given or L	2 No		1 ☐ Yes				rsican, etc.)	Spec	elc. Black		
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Baltimore,	- 1 5	20a. Method of Disposition				Plece of Dispo	sition (Nan	ne of			Dete	20c. Location		own, State	
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		23a. Part1. Enter the disees shock, or heart failure.	List only	one cause on	each line.	ath. Do not ent	er the mod	e or dyir	ng, such as	cardiac (or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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	/Medical Examiner	Immediate Cause (Finel disease or condition		, Sh	mt -	me!	, ac	2,6	in	20					
		resulting in death)		0	Due to	or as a conseq	juence of):		1						
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	an and rial-transit	Sequentially list conditions,		0	Due to	(or as a conseq	juence of):								
Ö,	Sian sian suries	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		•											
68760,	eeth certificate be executed attending physician and for use as the bunkl-transit clar/Medical Examir	that initieted events resulting in death) Last		Ç	Due to	(or as a conseq	uence of):								
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Records,	been s should										24a. Was perfo	en eutopsy med?	80	Vere autopsy finding vailable prior to ompletion of cause	js.
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or Vital	2 0 5	1 Ves 2 No		1 [2]		☐ ER/Outpatien	- 1		4LIN		me 5 Resi			ify)	
	The rest		ending		or injury oth, Day Year)	28b. Time of Injury	2	Bc. fnjur Wor			28d. Describe	now injury occ	urred	a 11.	4
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Division	tal or Attending P rs after death. al Director: After t ied in by the funers Certification:		etermined	288. Placi	e of fnjury - At ing, etc. <i>(Spec</i>	home, farm, str	eet, factory	, office			28f. Location (Street and Nur an, State)	nber or Rur	ral Route Number,	
	C in D					SN	zer				Portsh	Yest Sta	, Sai	ston.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 1			niner: On the b		nowledge, death nation and/or inv									
	within To the comple	29b. Signeture and the of or	rtifige				290	. Licens	e number	1		29d. Date sign	ned (Month.	Day, Year)	
	F \$ F 0	1	(_)					C.M.E	•		JANUA			
		/	7	YOU	_										
		30. Name aruf address of pe	rson who	Completed care		em 23a) (Type,									
		21 Days Grant Car	w	NOW		11 Penn	Stre	et,	Balt	mor	e, Mary	land 2	1201		
	State Registrar	31. Date filed (Month 5)		1999	Registrar's Sign	TIARUTE /	9.	In	K						
	negistiai						160	100							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month JAZ 530 HARLES DONE 4a Facility Name (If not institution, give street and number) Howard County General Hospital 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year Months Davs If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) 5. Sociel Security Number 214–14–0931 10XM 20 F Yrs. 1911 Md. Mar Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Columbia 1 ☐ Yes 2 No 10f. Zip Code 21044 10g. Citizen of Whet Country? Street and Number 10401 Twin Rivers Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) driver Par Gas 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Charles Albert Boone Alice Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Gertrude C. Boone (spouse) 10401 Twin Rivers Rd., Columbia MD 21044 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Alphonsus Cemetery 1-12-99 Woodstock, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel Parge Harght Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death 70DA Immediete Ceuse (Finel disease or condition resulting in death) Ma AB:ETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of) Enterisis, ATTENOS YEARS: 23b. Did tobacco use contribute to the cause of death? 1 □ Yee 2 □ No 3 □ Probably 5 □ Unknown 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy

Physician /Medical Examiner

The law requires that the death certificate be executed

has 10 2 page

this certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

within 2

or Attending Physician:

Hospital

0

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Md

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at

The Marylan

death

72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mentai Hygiene. Important: If frem 27 is marked other then "navy injury or other trauments.

Baltimore, Maryland 21215-0020

Examiner attending physicien and for use es the bunal-tran Physician/Medical signed by the a should I

Completed by Be To Certification:

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

1 Yes 2 No

completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 32 No 1 ☐ Yes 27. Manner of Deeth

5 Pending investigetion

6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No 28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1. Netural

2 Accident

4 Homicide

3 ☐ Sulcide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) and menner as steted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end pieca, end due to the cause(s) and manner stated.

EUCOTTUTY

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

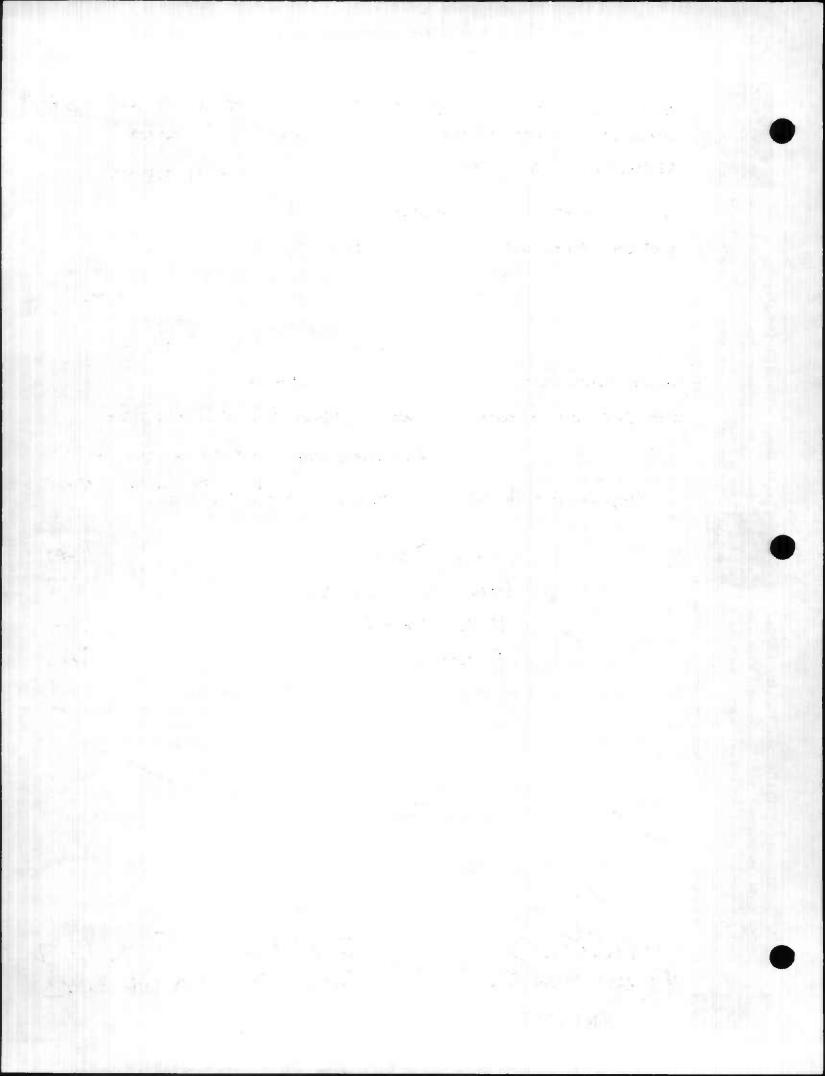
Medical

31. Date filed (Month, Day, Year)

1 1999



3460 EULOTT CENTER



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day BERARDELLI MARTO S 5__ 1999 JAN. 10:12 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 6/5/1925 6. Sex Birthplece (State or Foreign Country) Months Days Hours 1X) M 2D F 217-60-1620 73 ITALY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. CARROLL 1 DXYes 2 No MANCHESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3104 PARK AVE. 21102 USA. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Yes ②☐No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MECHANIC AUTO REPAIR 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) MICHAEL ANGELO BERARDELLI CATHERINE PASCUZZI 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) PATRICIA BERARDELLI -WIFE 3104 PARK AVE., MANCHESTER, MD. 21102 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) CEDAR HILL CEMETERY 1/9/99 BALTIMORE, MD. 22. Name end Address of Fecility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset end Death 23a, Part1, Enter shock, or he Immediate Cause (Final disease or condition resulting in death) espiratorn Due to (or es e conseguence of) pmaron Due to (or as a consequence of): Due to (or es a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown mulliphs 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? Lementia 2 1 No 22 No 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 DER/Outpatient 3 DOA

Physician /Medical Examiner

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After

To the Hospital or A within 24 hours after To the Funerel Direcompletally filled in b

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Certification: To

Medical

that the death certificate be executed

Box 68760,

P.O.

Records.

Division of Vitai or Attanding Physician: Physician

/Medical

Examiner

Funeral

Director

28a-(show

8 Nerns 23s Director

Funeral

by

Completed

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other treumstic event, the Madical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effect Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or have any injury or other treuments account.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last þ Completed

27. Manner of Death

1 Neturat

2 Accident 3 Suicide

4 Homicide

29b. Signature and title of certifier

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated. 29a, Cortific iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner stelled. one)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

MY

MARYLAND P33599

1 Yes 2 No

29d. Date signed (Month. Dev. Year)

cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple

Drive, Ste 34 Westminster, mosily hili as Airport 31. Date filed (Month, Day, Year)

28c. Injury et Work?

29c. License numbe

State Registrar

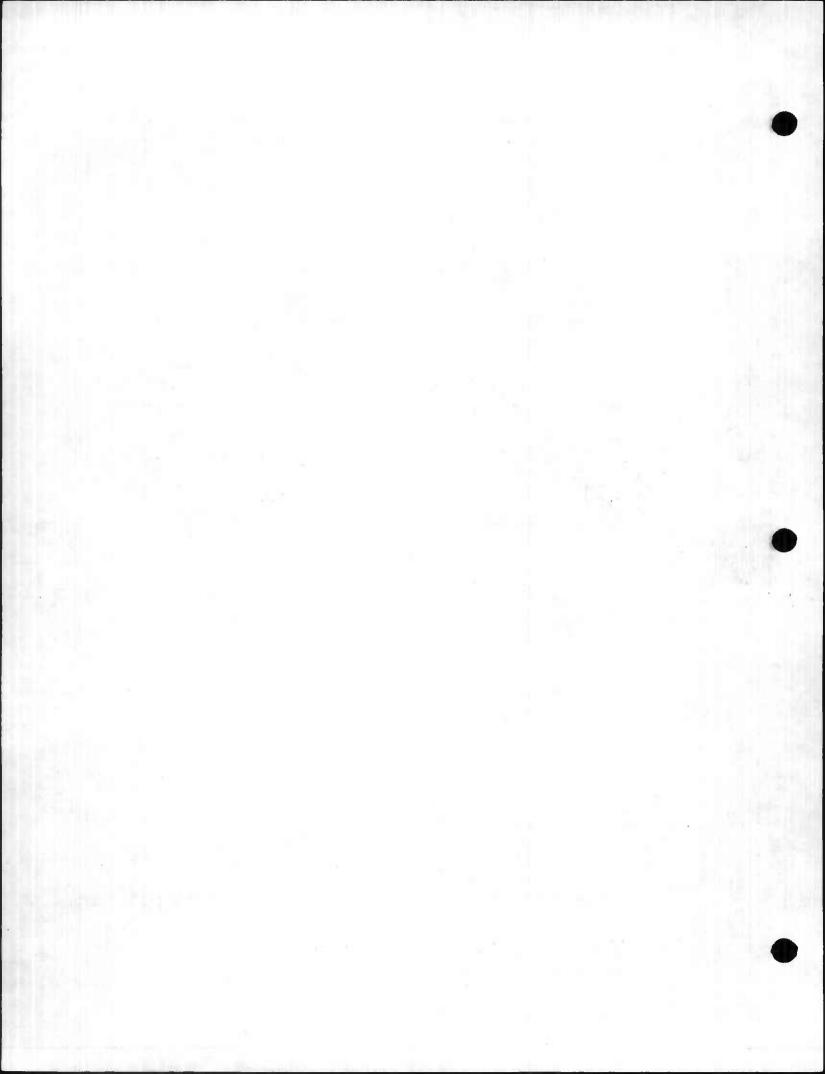
JAN 0 8 1999

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature Geneva

28a. Date of tnjury (Month, Day Year)



Box 68760. P.O. Records, of Vital

Baltimore, Maryland 21215-0020

signed b certificata To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director; After this result director; p. Division

> State Registrar

31. Dete filed (Month, Dey, Year)

JAN 1 1

Puran P.Mathur MD

DM~ MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signeture end title of cartifier

50 W Edmonston dr Rockville Md 20852 32. Registrer's Signeture

29c. License number 35 941 29d. Dete signed (Month, Day, Year)

Jan 5,1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 12, 1999 Dorothy M. Baker 11:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5016 60th Avenue Hyattsville Prince Georges | Months | Days | Hours | Min. | July 11, 1929 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖾 F Yes 69 183-24-9916 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or herns 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1034 Osage Street 20903 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 12 permit. Pages 1 and 2 should be fits.
Department of Heath and Mental Hy
Important: if flem 27 is marked offsarry injury or other treumatic event,
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence McMasters Velva Shultz 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy C. Burrows (daughter) 5016 60th Avenue, Hyattsville, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 XBurial 2 Cremation 3 Removel from State ran's Cemetery | 1/21/99 | Cheltenham, MD
22 Name end Address of Fecility Francis J. Collins Funeral 4 Donetion 5 Other (Specify) MD Veteran's Cemetery 21. Signetyreyof Funerel Service Liga Home, Inc. 500 University Blvd. West Clour Silver Spring, MD 20901 ance Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel 1LTI FORME

Examiner

Box 68760

Records, P.O.

Division of Vital

disease or condition resulting in death) Examiner the death certificate be executed physician and s the burial-trans

Physician/Medical 80 for use as 980 signed by t by Completed page 2 s Hospital or Attending Physician: The hours after death.

14 hours after death.

Funeral Director: After this certificate tely filled in by the funeral director, pe 89 To Certification:

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certificate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

SIUMA Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23h. Did tohecco use contribute to the cause of death? 1 Yes 2₺ No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation

6 ☐ Could not be

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 125 Cartifying Physician (Check only one) 29b. Signature

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

29c. License number

D08754

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year)

January 13, 1999

e of death (Item 23a) (Type, Print)

M.D., Thomas A. Bensinger, 7525 Greenway Center Drive, Greenbelt, MD 31. Date filed (Month, Day, Year)

State Registrar

edical

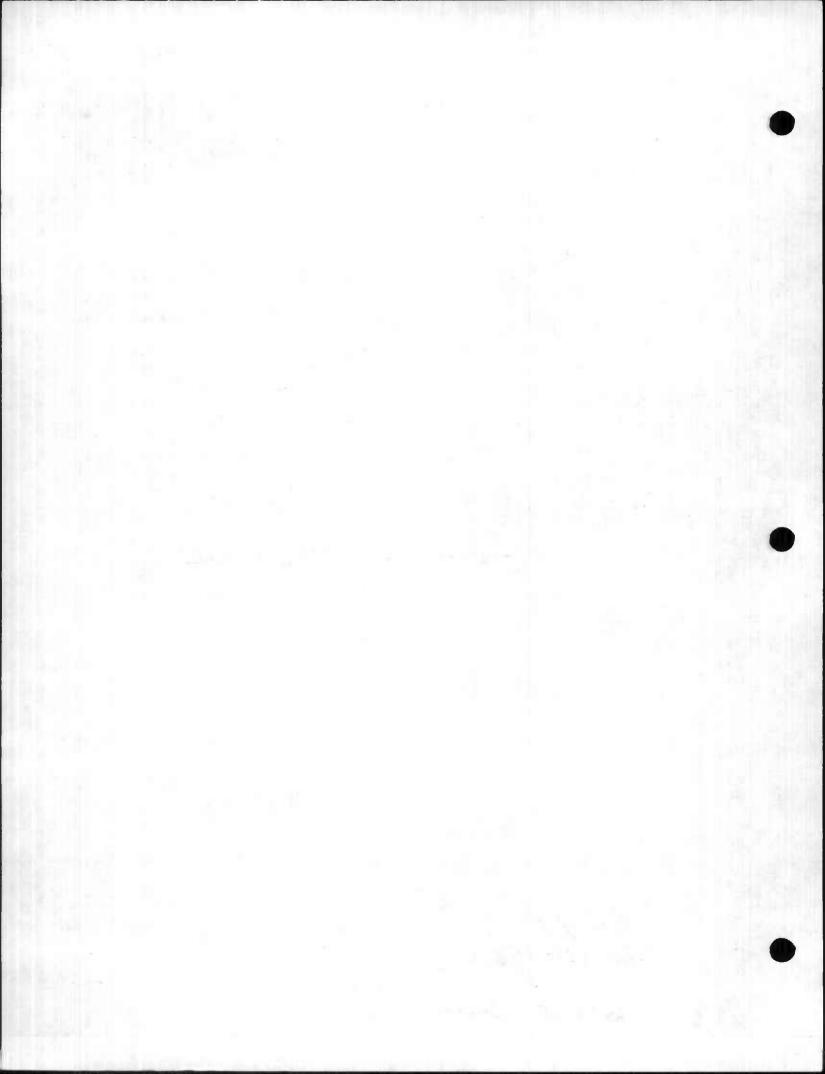
1999 **JAN 14**

32. Registrar's Signature

oals

To the Hospital o within 24 hours aff To the Funeral Di completely filled in

10



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Deeth BANG **Physician** BEBE MARY 3:25 PM /Medical 4e Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Vindobona Nursing Home Braddock Heights Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 F Months Days Yrs. 70 Director Sept. 14, 1928 521-30-2458 Colorado Usual Residence of Decedant the Marylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 4627 Feldspar Road 21769 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Stetus Armed Forces?

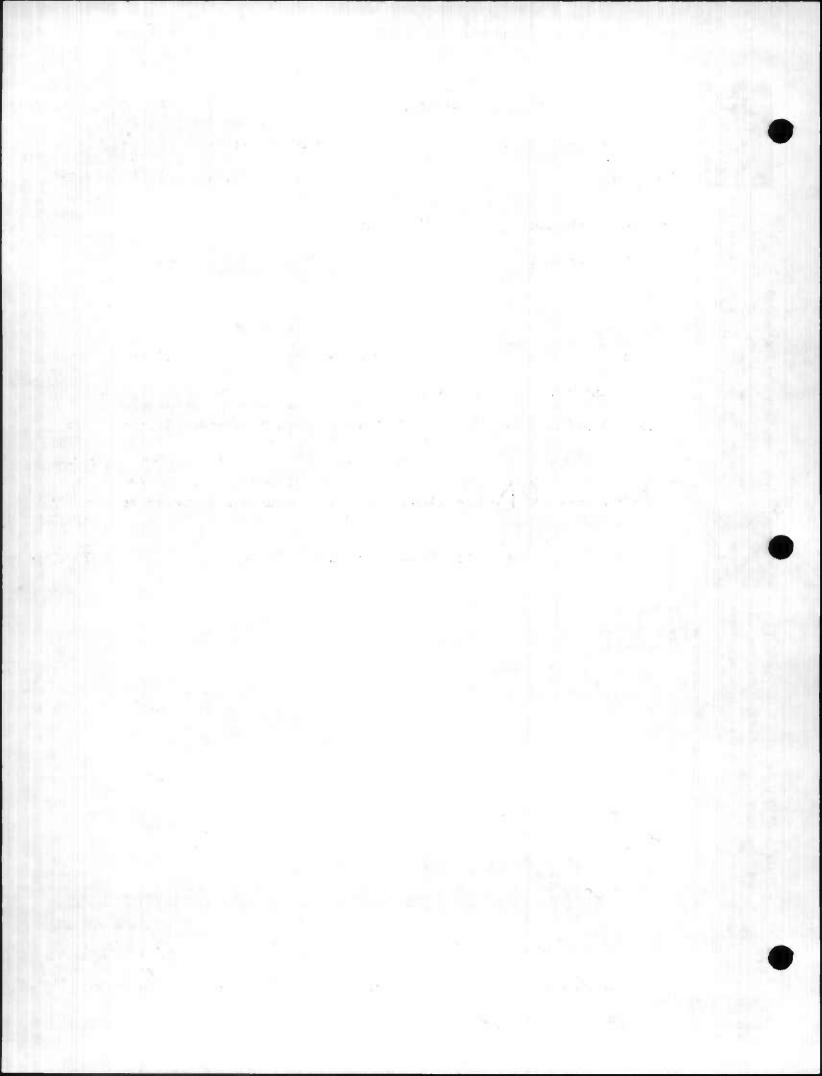
1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify þ 3 Widowed 42 Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Peges 1 and 2 should be filed within Department of Health end Mentel Hygiene. Important: If item 27 is marked other than any Injury or other traumatic avent, the Ma Elamentary/Secondary (0-12) College (1-4or 5+) 12 Travel Agent Private Business 18. Mother's Name (First, Middle, Maidan Sumame) 17. Father's Nama (First, Middle, Last) Be Benjamin Burnand Zola Selman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benie L. King/Daughter 4627 Feldspar Road, Middletown, Maryland 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 17 Buriat 2 Cremation 3 Removal from State 1/16/99 Denver, Colorado 4 ☐ Donation 5 ☐ Other (Specify) Crown Hill Cemetery 22. Name end Address of Facility DeVol Funeral Home Signature of Funeral Service Licenses Librario East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Batween Onset end Death Physician MULTIPLE SCLEROSIS /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examiner end I-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated avants resulting in death) Lest Due to (or as a consequence of): physician e Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) ettending pl the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dld tobacco use contribute to the cause of death? signed by the 1 Yes 2 10 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 hes certificate 1 Yes 2/1 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician: 24 hours efter deeth. Funeral Director: After this certific funeral director, Be 25. Was casa referred to medical examiner? 26. Placa of Death (Check only one) Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accident 3 Sulcide 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours 16 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Cartifiar To the Hosp within 24 hou To the Fune completely fi edical (Check only one) 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Yaar) JAN 12 1999 32. Registrar's Signature

Brinswilly

AULS



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Yaar Betty Lou Benbow 7, 1999 9:00 AM January 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 7420 Lakeview Drive #109 W Montgomery Bethesda If Undar 1 Yaar | If Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1 □ M 2 🛱 F Months Days Hours 76 481-16-5913 Yrs. January 25, 1922 Iowa Usual Rasidence of Decedant 10c. City, Town or Location 10d. Insida City Limits 10a. Stata 10b. County 1 ☐ Yas 2 No Maryland Montgomery Bethesda 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 7420 Lakeview Drive 109-W 20817 United States 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 X No Specify: White 3 X Widowad 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantery/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Ommund Pederson Bertha Kinseth 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Robert Michael Benbow/Son 7420 Lakeview Drive 109-W, Bethesda, Maryland 20817 20b. Placa of Disposition (Nama of cematary, crematory or other placa) January 9, 1999 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Removal from Stata 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia \$1. Signature of Funesal Sarvice Licen 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, MU0846 To rumphrey Funeral Home/Be 7557 Wisconsin Avenue, Bethesda, Market Consiner and State of Complete Consideration of the Course of the C 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximata Intervel Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Acute Respiratory Failure 3 Days Dua to (or as a consaquence of). Cardiac Arrythmia Many Years Sequentially list conditions, if any, laading to immadiata ceusa. Entar Undartying Ceuse (Disease or Injury that initiated avents rasulting in daath) Last Dua to (or as a consaquance of): Dua to (or as a consequance of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy parformad? complation of causa of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was casa rafarrad to medicel axaminar? 28. Place of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 XYas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Yaar) 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be data minad 3 ☐ Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 29a. Cartifian 1 🔀 Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha ceusa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stellad. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) Wellen D37840 January 7, 1999 30. Name and address of person who computed ceusa of daath (Itam 23a) (Type, Print) Brent A. Berger, M.D., 11125 Rockville Pike #209, Rockville, Maryland 20852-3179

State Registrar

Physician

/Medical

Examiner

Funeral

Director

28a-f show

r than "naturel", or items 23a or 28a-f show the Medical Examines must be notified at

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Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene.
Important if frem 27 is marked other than "natures" — pages.

Physician /Medical

Examiner

attending physician and for use as the buriel-transit

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certificate

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After 1

To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A complataly filled in by the fi

or Attending Physician:

daath.

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Certification:

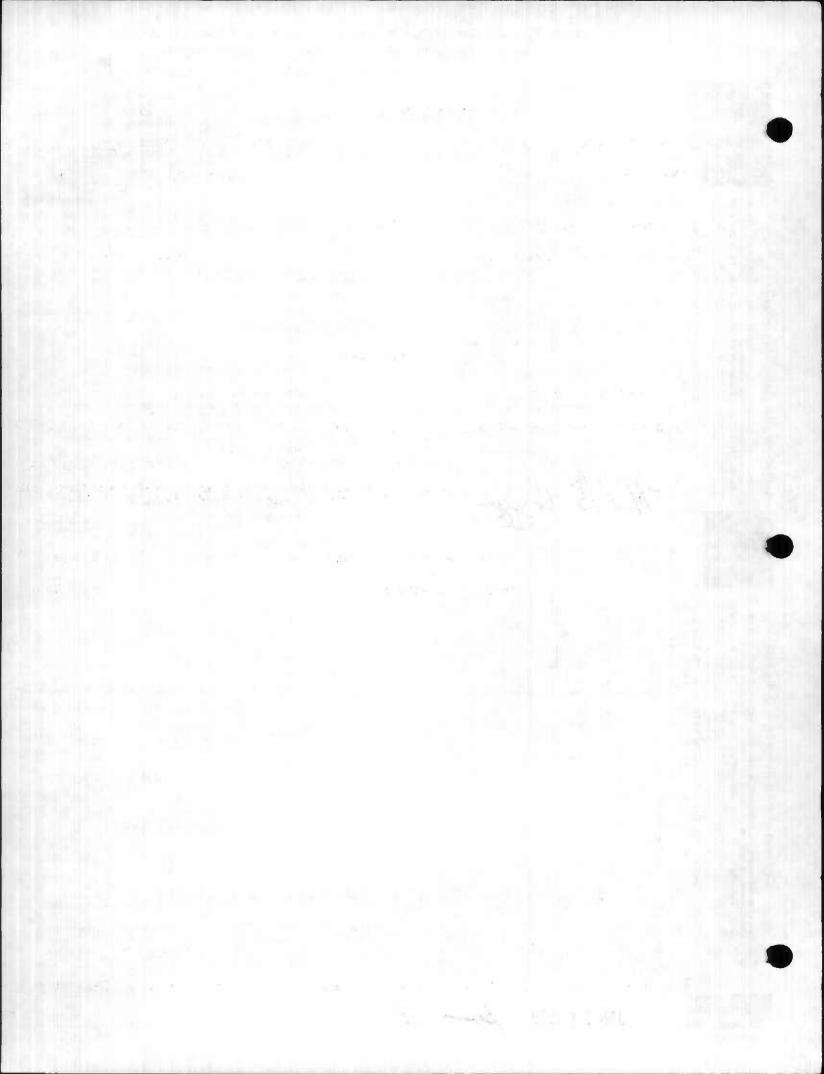
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31. Data filad (Month, Day, Year)

JAN 1 1

1999

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Day 1999eer **Physician** JAN. ACHSAH BENNETT 9, 1734 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY Washington Adventist Hospital Takoma Park If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) Mar 14,1937 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months Hours 1□M 2\ F Maryland 61 213-42-6905 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits worle must be notified at 1☑ Yes 2□ No Director Silver Spring Montgomery Md 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 20910 U.S.A. 8560 2nd Ave #321 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: Hemm. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11 Meritel Status Bleck, White, etc. e filed within 72 hours after il Hygiene. other then "netural", or its 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 20 No Specify: by 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Residence 12th Grade Housewife 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Peges 1 and 2 should be flik Department of Health end Mental Hy Important: If item 27 is marked oth any Injury or other treumatic avent Be Roberta Pumphrey William Smith 19e. Informent's Neme/Reletionship (Type(FD) aughter) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Helen R. Bennett 311 Hillside Terr, Landover, Md #20785 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Ramoval from State 1/15/99 Sandy Spring, Md 4 ☐ Donation 5 ☐ Other (Specify) Ash Memorial Cem. 22. Name and Address of Facility
Snowden Funeral Home P.A. 20850 21. Signature of Funerel Service Licenses 246 N. Washington St, Rockville, Buss Md 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feijlurg. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disaese or condition resulting in deeth) Examiner Physician/Medical Examiner ware The lew requires that the death certificate be asscuted physicien and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a con-USe as P.O. I Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Wera autopsy findings evailable prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed Cabalie 20 No 2A No 1 ☐ Yes 1 ☐ Yes of Vital or Attending Physicien: 25. Was case referred to medicat exeminer?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Division 1 Neturef 5 Pending invastigation s effer dec. 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital
within 24 hours
To the Funeral Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier 29c. License number 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Rem 23a) (Type, Print) 4. 7610 Canall for 31. Date filed (Month, Day, Year)

DHMH 16 Rsv 6/95

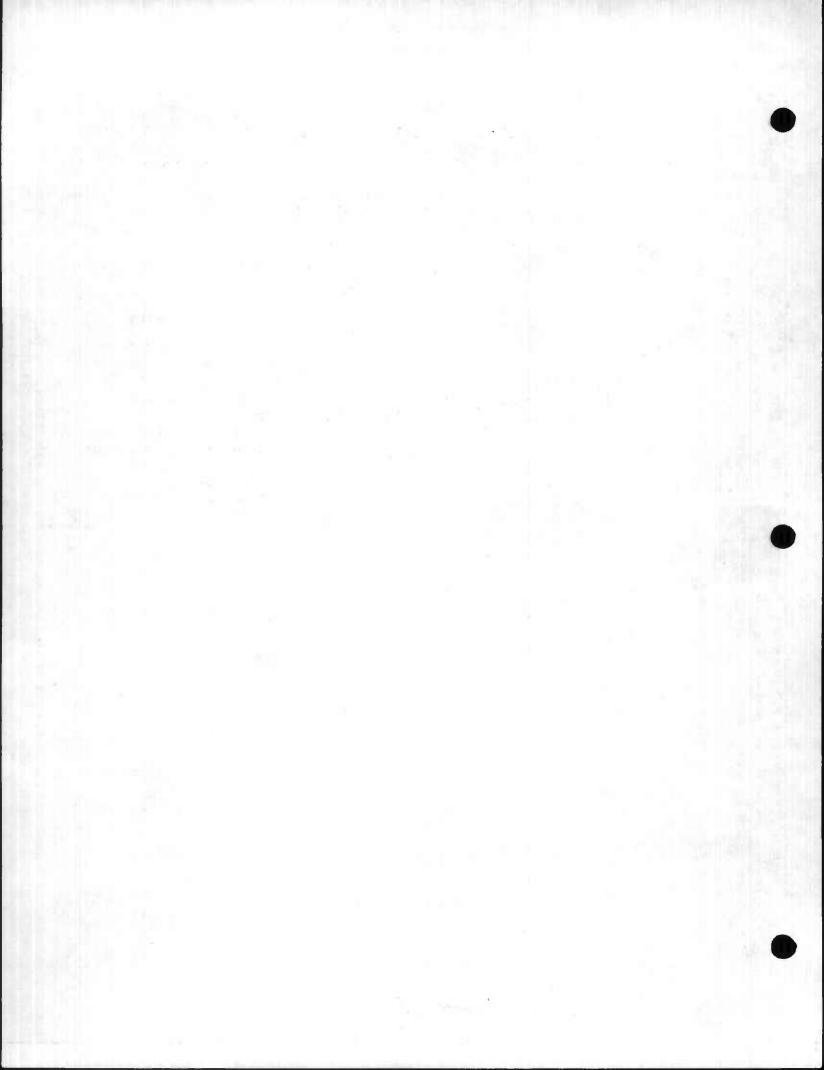
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Registrar

32. Régistrar's Signeture

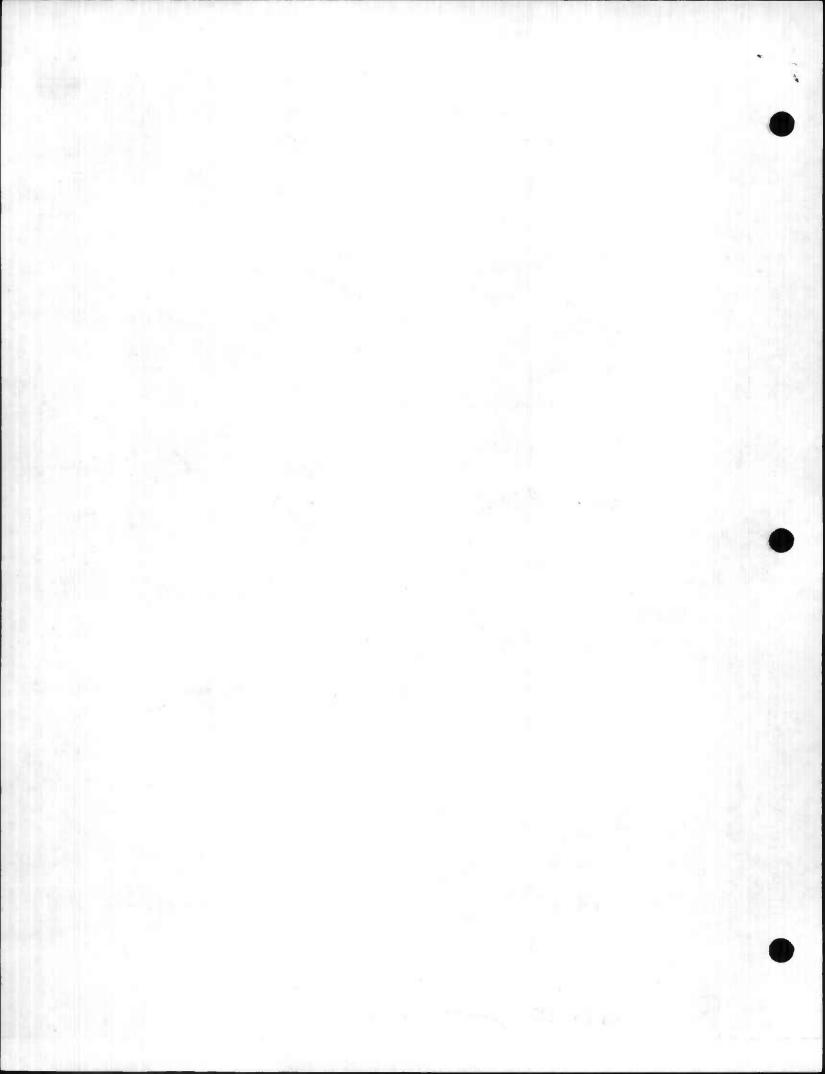
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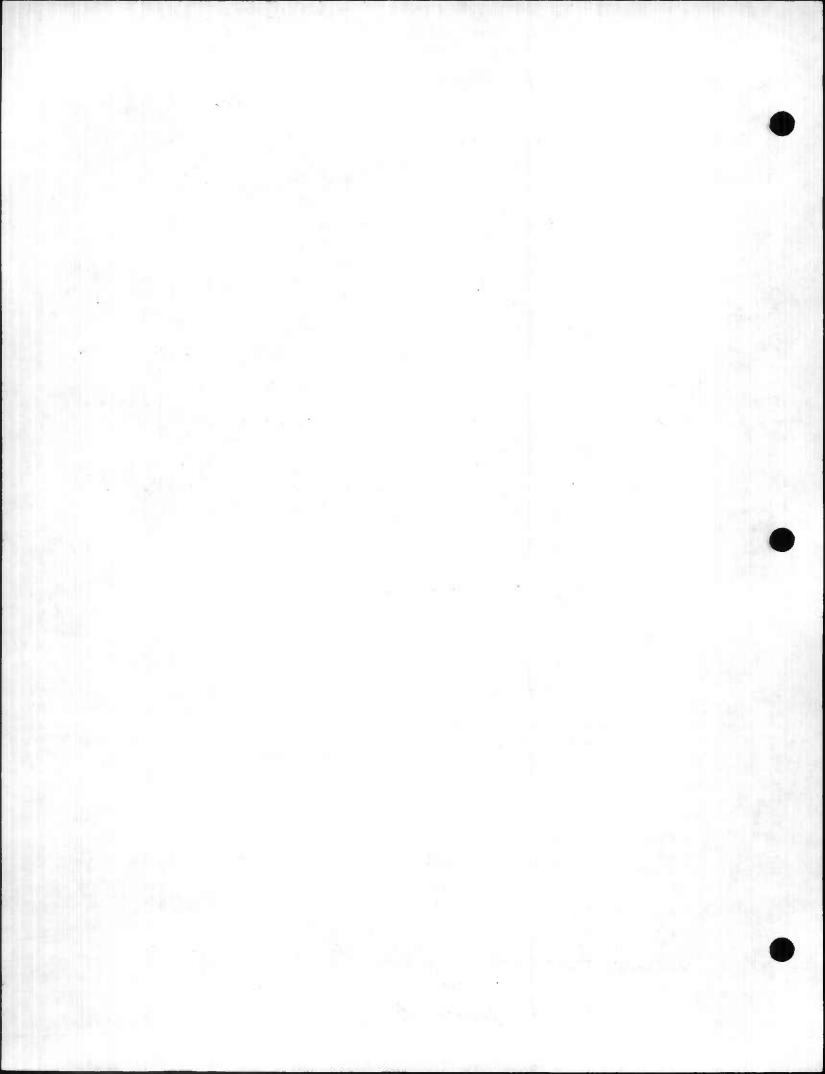
State of Maryland / Department of Health and Mental Hygiene 9 0 | 53 |

		Cer	tificate of	Death		Reg. No.		701		
1. Decedent's Neme (First, Middle, La:					2. Dete of De Month	Dey	Year	Time of Death 1:30AM		
Gertrude Evelyn Berry January 7 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of De										
4a Facility Name (If not institution, give										
Manor Care Silve	1		W Hadard Wass	Silver			ntgome			
443-14-1010	D	yrs. last birthday) 97 Yrs.	If Under 1 Year Months Days			y, Year) 1901	9. Birthplace Country) Oklaho	(State or Foreig		
Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
MD Montg			1 ☐ Yes 2 🖾 N							
10e. Streef and Number	10g. Citizen of V	What Country?								
1106 Kathryn Roa	.d		2090)4		USA				
11. Marital Stetus	12. Wes Decedent Ever Armed Forces?	in U,S. 13. V	Was Decedent of I	Hispanic Origin? (S lan, Mexican, Puel	Specify Yes or No	- 14. Rec	e - American II	ndian,		
1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No		to mount otc.,	Specify		ζ		
15. Decedent's Ed		16a. Deced	lent's Usual Occu	pation		16b. Kind of Bu	usiness/Industr	y		
(Specify only highest gra		(Give	kind of work done DO NOT use retire	during most of wo	orking					
Elementery/Secondary (0-12)	College (1-4dr 5+)	College (1-4or 5+) Homemake				0wn	Home			
17. Father's Name (First, Middle, Last)			N III	18. Mother's Ne	me (First, Middle,	Maiden Sumer	10)			
Lewis Bruner				Mary	Henders	on				
19a. Informant's Neme/Relationship (Type, Print)	19b. Mailin	no Address (Stree	t end Number or Fi			State, Zip Coo	de)		
Candace Stepp	(daughter)			Road, Si			20904			
20e. Method of Disposition		Ob. Place of Dispo			Defe	20c. Location -				
1 ☑ Burlel 2 ☐ Cremetion 3 ☐	removal from State				1 12 00					
4 Donetion 5 Other (Specify		Crown Hil			1-13-99	Tulsa, (OKTanon	ia col		
21. Signature of Funeral Service Licensee 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver SPring, MD 20901										
23a. Pert1. Enter the disease, or comp	plicetions that caused the					rrest,	Api	proximate erval Between		
23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.										
Immediate Ceuse (Finel										
disease or condition resulting in death) a. 7 / Y U MONTA										
	Due	to (or es a conseq	uenca of):				1			
	b		Α.				1			
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	Due	to (or as e conseq	uence or):				1			
Cause. Enter Underlying Ceuse (Disease or injury that initiated events	c									
resulting in death) Last	Due	to (or as e consequ	uenca of):				1			
	d									
Part If. Other algnificant conditions of	ontributing to death but no	ot resulting in the un	nderlying cause gi	ven in Pert I.	23b. Did	tobacco use co	ntribute to the	cause of deat		
					10	Yes 2000	3 Probebl	ly 4□Unkno		
					24e Wes	an eutopsy	24b. Were a	autopsy findings		
					perfo	rmed?	comple	ole prior to etion of cause		
						A description	of deat	h?		
					10	Yes 2QMg	1 ☐ Ye	s 2 No		
25. Was case referred to medical examiner?					eath (Check only o	ne)				
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatien	t 3LI DOA		Home 5 Resi	dence 6 □Oth	er (Specify)			
27. Menner of Death ↑ Shaturel 5 ☐ Pending	28a. Dete of Injury (Month, Day Ye	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe	how injury occur	red			
2 Accident investigation		M 1 Yes 2 No								
3 Suicide 6 Could not be determined	286. Pieca of injury -	28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street end Number or Rurel Route Number, City or Town, State)				
29a. Certifier (Check only one) Certifying Physics 2 Medical Example 2 Medical Exam	ysician: To the best of my niner: On the basis of exa and manner stefed.	y knowledge, deeth minetion end/or inv	occurred at the tivestigation, in my	me, dete end plec opinion, death occ	e, end due to the urred at the time,	cause(s) and ma date and place,	anner as stated and due to the	d. cause(s)		
29b. Signature and fittle of certifier			29c, Licen	se number		29d. Date signe	d (Month. Day	Year)		
Jenny y A	how the		7111 1810	W. Allendar	(1	21/0	7/90			
	,			4326		4/0	1117			
30. Name end eddress of person who	completed cause of death	(Item 23a) (Type,	Print) Jenny	Y. Moy,	M.D.					
15952 Balt	more tre	- Laur	el MD	2070						
31. Dete filed (Month	, Day, Year)	, Day, Year) 32. Registrar's	, Day, Year) 32. Registrar's Signeture	, Day, Year) 32. Registrar's Signeture	, Day, Year) 32. Registrar's Signeture	, Day, Year) 32. Registrar's Signeture	, Day, Year) 32. Registrar's Signeture	, Day, Year) 32. Registrar's Signeture		



State of Maryland / Department of Health and Mental Hygiene 9 9 153

					Ce	rtificat	te of	Death			Reg. No.			
		1. Decedent's Name (First, Middle	, Last)							2. Date of De Month		V	3. Time	of Death
	sician	Joseph Alfred	Bonanno							January	11, 19	99	7:2	5 AM
V-0.0	edical miner	4a Facility Name (If not institution,	, give street and no	umber)				4b. City, To	wn, or L	ocation of Deat	4c. Count	y of Death		
LAG		Randolph Hill	s Nursing	e Home				Wheat	on		Mont	gomer	v	
Free	no.		6. Sex		. last birthday		r 1 Year	If Under		8. Date of Bir	th			e or Foreign
Fune Direct		579-32-9463	12XM 2□ F	89		Months	Days	Hours	Min.	Feb. 1	v Year	Ita	ntry)	e or Foreign
		Usual Residence of Decedent								1.00. 1	1, 1,00	100	- 7	4
land		10a. State 10b. County		10c. C	ity, Town or Le	ocation		N.				1	Od. Inside	City Limits
dany fah	ঠ	MD Montgomery Rockville											1 🗆 Y	es 2 No
the I	2	10e. Street and Number	omery		ROCK						10g. Citizen of	What Cour	nto 2	
5 6	ā	10e. Street and Number 10f. Zip Code									rog. Citizeri di	WHILE COU	ntry :	
ath 23,	la l	13015 Parkland						0853				SA		
e de	Funeral Director	11. Marital Status	Armed F			Was Dece If Yes, spe	ident of l ocify Cub	Hispanic Ori an, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		ce - Americ ick, White,		
2 4 5	II.	1 Never Married 2 Marrie	If Yes, G	2⊠ No		1 Yes	21 No	Specify:			Specia	W: T.TL	2 4	
d within 72 hours at giene.	dby	3 ☑ Widowed 4 □ Divorced	Year or 1	Dates:								WI	ite	
72 72 H	i e	15. Decedent' (Specify only highes)	16a. Dece	dent's Usu	al Occu	pation during mos	t of work	cina	16b. Kind of E	lusiness/In	dustry	
L E	i de	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT u	se retire	ed)						
N N N N N N N N N N N N N N N N N N N	00	5			Bar	ber					Self-	emplo	yed	
Maryland d 2 should be file th end Mental Hy 7 le merked othe traumetic event	Be Completed	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Nam	e (First, Middle,	, Maiden Sumai	ne)		
Aenti de di	To	Placido Bonanno)					Rosa	aria	Musume	ci			
Sho of s		19a. Informant's Name/Relationsh	ip (Type, Print)	102.07	19b. Maili	ng Addres	s (Stree	t and Numb	er or Au	ral Route Numb	er, City or Town	, State, Zip	Code)	
C NI		Sara B. Comeau	(daug	hter)	13015	Park	clan	d Driv	7e. 1	Rockvil.	le. MD	2085	3	
S T E		20a. Method of Disposition	, , ,		Place of Dispo	sition (Na	me of			Date	20c. Location	- City or To	own, State	9
mit. Pages 1 ar spartment of Heal portant: If Item.	5	1 Burial 2 Cremation			cemetery, cre					111100				
Tantant Canada		4 □ Donation 5 ☑ Other (Sp		ment Ga						/14/99 ancis J				
D Separation	900	21. Signature of Funeral Service L	icensee			ome,				iversit				
5)	a	Oleven D	Strond					ring,		20901	, Diva.	11000		
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that	caused the dea						or respiratory a	rrest,	1	Approxim	nate
Physicia	an											1	Onset an	
/Medic	al	Immediate Cause (Final disease or condition Pneumonia									7 da	ivs		
Examin	er	resulting in death)	a		or as a conse	nuanaa af)						1	, 40	2,0
	je l		Chw						Dia			1	20	
De La	Ē		b. CIT	conic Oh				onary	DIS	ease		1	20 ye	ears
one c	X	Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying									-			
BOX BB/BU, eath certificate be executed attending physician end for use as the bunal-transit	Medical Examiner	Cause (Disease or injury that initiated events	С		N 13/7- a -1 -111							1		
the part of	P	resulting in death) Last		Due to (or as a consec	quence of):						1		
Certification	3		d											
es that the death cerigned by the attendin	Physiclan													
the day	ysi	Part II. Other significant condition	ns contributing to d	death but not re	sulting in the u	inderlying o	cause gi	iven in Part I	l.	23b. Did	tobecco use co	ontribute to	o the caus	e of death?
d by	4	Arthritis								10	Yes 2E No	3 Pro	bably 4	Unknow
ne law requires that has been signed by age 2 should be detailed	by											1		
v require been si should	Completed	Senile Dementi	ia (Alze	imer's))					24a. Was perfo	an autopsy omed?	av.	allable pri	sy findings or to
D S TO W												of	mpletion o	of cause
The la	E									10	Yes 2 No	1[☐Yes 2	.□ No
	BeC	25. Was case referred to medical		- Chillian				26 Place	of Dool	th (Check only o	nnel			
Physician: this certific ral director,	0	examiner?	Hospital:	I tonnetions OF	7590-4	- 2 D	Ot Ot	hor				has (Cassi	6.1	
0 = = 0		1 Inpatient 2 LENOutpatient 3 LI DOA 4 LEN Nursing Home 5 Li Hest								Residence 6 LlOther (Specify) ribe how injury occurred				
Afte and	lon	1 ⊠Natural 5 ☐ Pending		nth, Day Year)	Injury				No					
Attending or death. ector: After by the fune	Ca	2 Accident investigation M 1 Yes 2 No							29f Location /	Street and Num	har or Prin	al Poudo Ai	lumbar	
DIVISION TO MOSPITAL OF Attending In 24 hours after death. The Funeral Director: After pletaly filled in by the fune	Certification:	4 Homicide determin	ned 286. Plac build	e of injury - At I ling, etc. (Spec	nome, tarm, st ify)	reet, factor	у, опісе			City or To		Der OF Huri	BI MOUTO N	umber,
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4 hours	edical		Physician: To the booming: On the b											e(s)
To the H within 24 To the F complete	8	900)		stated.										
To To	2	29b. Signature and title of certifier	V	1		29	c. Licen	se number			29d. Date sign	ed (Month,	Day, Year	7)
1-		0.	TIN 1	7/1 C	MI	>	D0	7471			January	12,	1999	
4		30. Name and address of person w	no completed cau	se of death (Ite	m 23a) (Type.	Print)								
		Paul T. Noone,					70.	Rocky	1110	. MD 2	0852			
	State	31. Date filed (Month, Day, Year)		Registrar's Sign			,	-10 C1(V)		, 2				
	State istrar	IAN 13		reneva	1 4	1	20- 4	/1						



32. Registrer's Signeture

Rockville, MD 20852

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Dey, Year)

JAN 13 1999

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January 11, 199

Bonnett

5 Market Annual Carlot And St. Co., Co. of the Co. The transfer of the second of NAME OF STREET WAR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Benjamin Paull Bretz 12, 1999 1:21 PM January 4a Fecility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1⊠M 2□ F Yrs. 171-30-5140 Pennsylvania June 8, 1907 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nas 2 No Pennsylvania Dauphin Harrisburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17112 United States 4081 Greystone Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, etc. 1 X Yes 2 No If Yas, Giva Yaar or Datas: 1 Never Merried 2 Married 1□ Yes 2♥ No Specify: Specify: 3 Nidowad 4 Divorced WW TT White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry New Cumberland Elemantary/Secondary (0-12) College (1-4or 5+) Army Depot Analyst 17. Fathar's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin F. Bretz, Caroline Paull 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Millbridge Apartments 1341 Blackwood-Clementon Road, Clementon, NJ 08021 19e. Informent's Neme/Ralationship (Type, Print) Joan E. Bretz (daughter) 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Steta Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1-13-99 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac er respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final Subdura hemorrhage disaasa or condition rasulting in daath) 009 Sequantially list conditions, if any, leeding to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated avants resulting in daath) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be 2

Funeral

Director

Item 27 is marked other than "natural", or Itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or free eny Injury or other traumatic event

Baltimore, Maryland 21215-0020

edicai Examiner To the Hospital or Attending Physician: The law requires that the death certificata be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunish transit

Division of Vital Records, P.O. Box 68760

Part II. Other significant conditions of Recent pu	1	sulting in the underlying		23b. Did tobacco use co	ontribute to the cause of death
Demention	/			24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death? 1 □ Yas 2 No
25. Was case refarred to medical			26. Place of De	eth (Check only one)	
1 Yas 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient 3□ I	OOA Other: 4 Nursing	Homa 5 ☐ Residence 6 ☐Ot	her (Specify)
27. Mennar of Death Naturel 5 Pending Accident invastigation	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	rred
3 ☐ Suicida 6 ☐ Could not be datarmined	28e. Plece of Injury - At h building, atc. (Speci	ioma, farm, street, factory)	ory, office	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,
29a. Cartifier 1 Certifying Ph. (Check only one) 1 Medical Example 1	raician: To the best of my known iner: On the basis of examinating end mennar stated.	owledge, death occurre ation and/or investigation	d et the tima, date and plac on, in my opinion, death occ	e, end due to the cause(s) and murred at the time, date and plece	nannar es stated. , and due to the cause(s)
29b. Signetura and title of certifier		4.0	9c. License number	29d. Date sign	ed (Month, Day, Year)

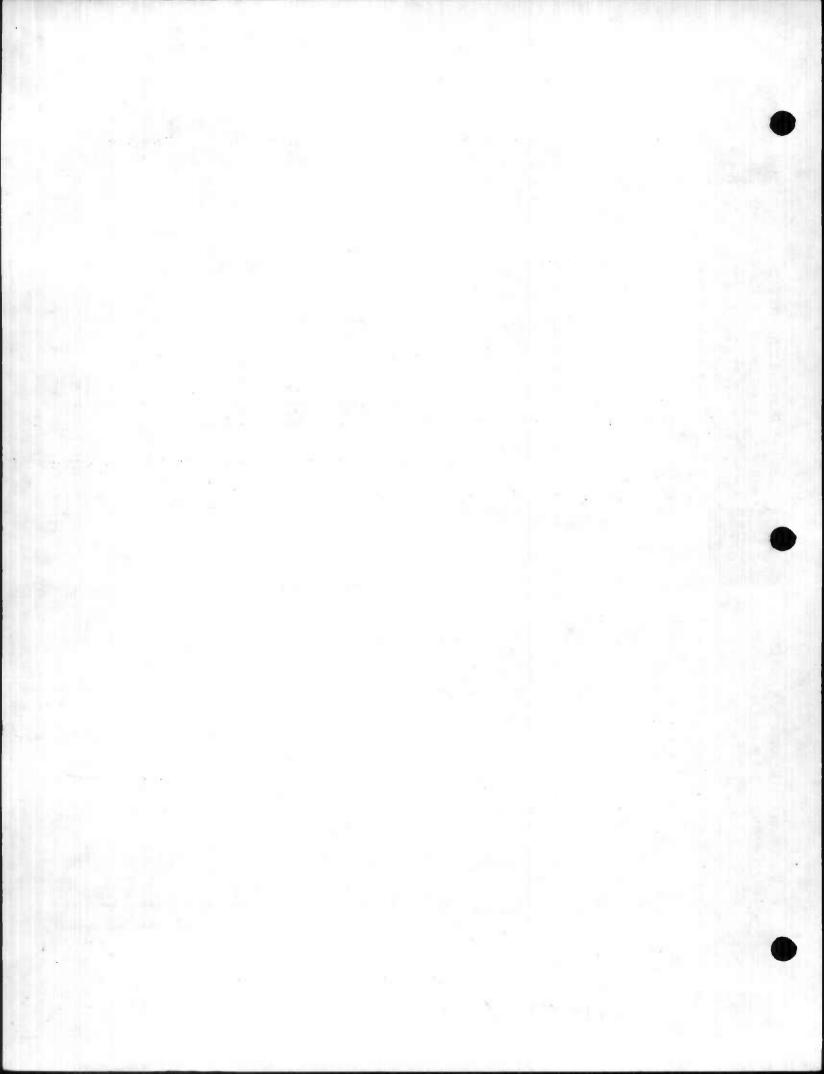
State Registrar 31. Data filed (Month, Day, Year) **JAN 14**

Paul Armstrons mo

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

14201 Laurel PK. Dr. # 102 Laurel MD 20707 32. Registrar's Signature

Due to (or es e consequence of):



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month **Physician** Robert Charles 1999 0600 Jan /Medical 4a. Fecility Name (If not institution, give street, and number) 4b. City, Town, or Location of Deeth 4c. County of Deatl Examiner Brad 14228 9 haw SILVEY Dri DYIMA 02n 6. If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Feb. 3, 5. Sociel Sacurity Number 6 Say 7. Age (In yrs. last birthdey) 9. Birthpleca (Stata or Foreign **Funeral** Months 12 M 2□ F Pennsylvania Yrs. 49 Director 155-36-8614 Usuel Rasidence of Decedent filed within 72 hours efter deeth with the Maryland 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 6 or items 23e 20905 United States Funeral 14228 Bradshaw Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amaricen Indien, Black, Whita, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married Specify: White 1 Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Peges 1 end 2 should be filed within nent of Health end Mental Hygiene. int: If Nem 27 Is marked other than Elementery/Secondary (0-12) College (1-4or 5+) Computer Sciences Corp Computer 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Elsie Strese Charles S. Budd 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) permit. Pages 1 and 2 s Department of Health or Important: if Item 27 is any injury or other trau 14228 Bradshaw Drive Silver Spring, MD 20905 Rosemary Budd/Wife 20a. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 1/15/99 Rockville, MD 22. Name end Address of Fecility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Ligensae moun 11800 New Hampshire Ave. SilverSpring, MD 20904 If the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrast, heart failure. List only one cause on each line. Approximeta Intervel Between Onsat and Daath **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of): The law requires that the death certificete be executed buriel-transit and Sequantially list conditions, if eny, leeding to immadiate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequance of): ettending physician Physician/Medicai the Dua to (or es e consequence of): Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? rthis certificate has been signed by rel director, page 2 should be detected 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to Completed 24e. Wes en eutopsy parformed? completion of ceuse of deeth? 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Wes cese referred to medical 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 Yes 2□ No funerel 27. Menner of Death 28e. Dete of Injury (Month, Dev Year) Certification: 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation Naturel Injury death. 1 Yes 2 No 2 Accident or Attend efter death Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide To the Hospital within 24 hours e To the Funeral C completely filled Hospital of the Pours e 29a Certifier 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

State Registra

29b. Sid

31. Dete fited (Month, Day, Yeer) **JAN 13**

and title of certifier

BRECHER, MD 32. Registrer's Signature

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print)

DME

OME

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29c. License number

Dooye

merca

29d. Date signed (Month, Dev. Year)

Park

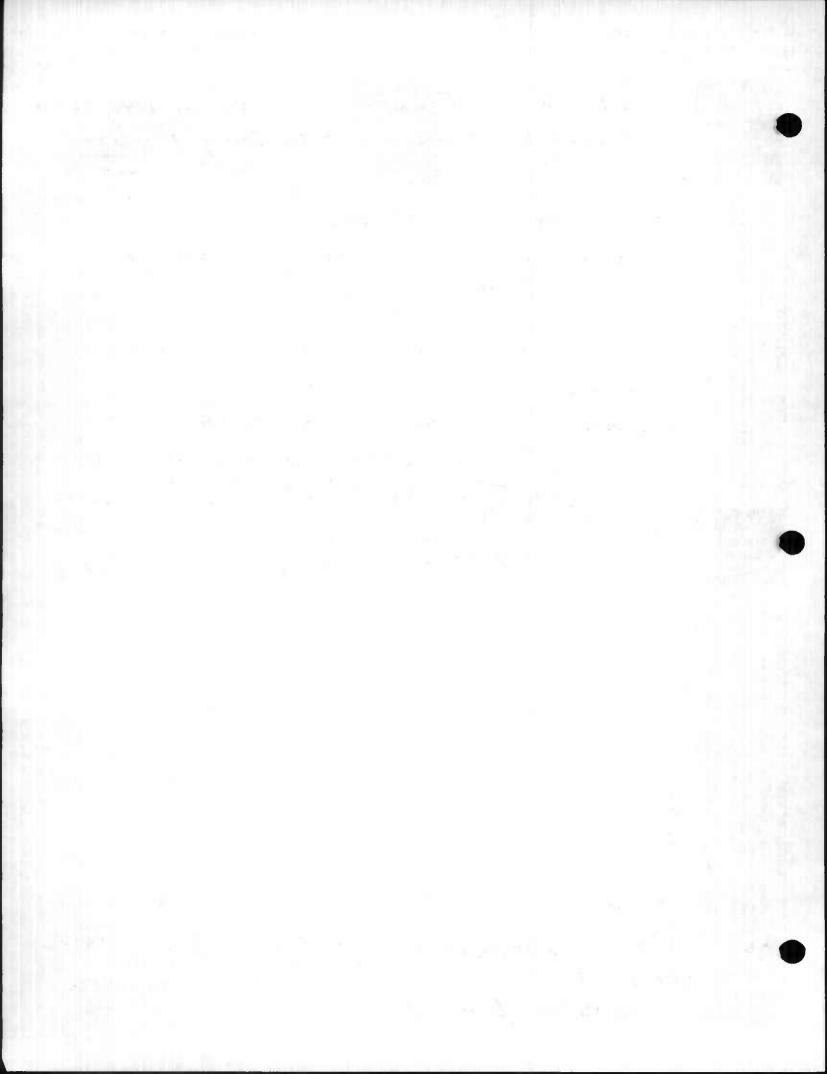
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21215-0020

SBaltimore, Maryland

P.O. Box 68760.

Division of Vital Records.



James Brans

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

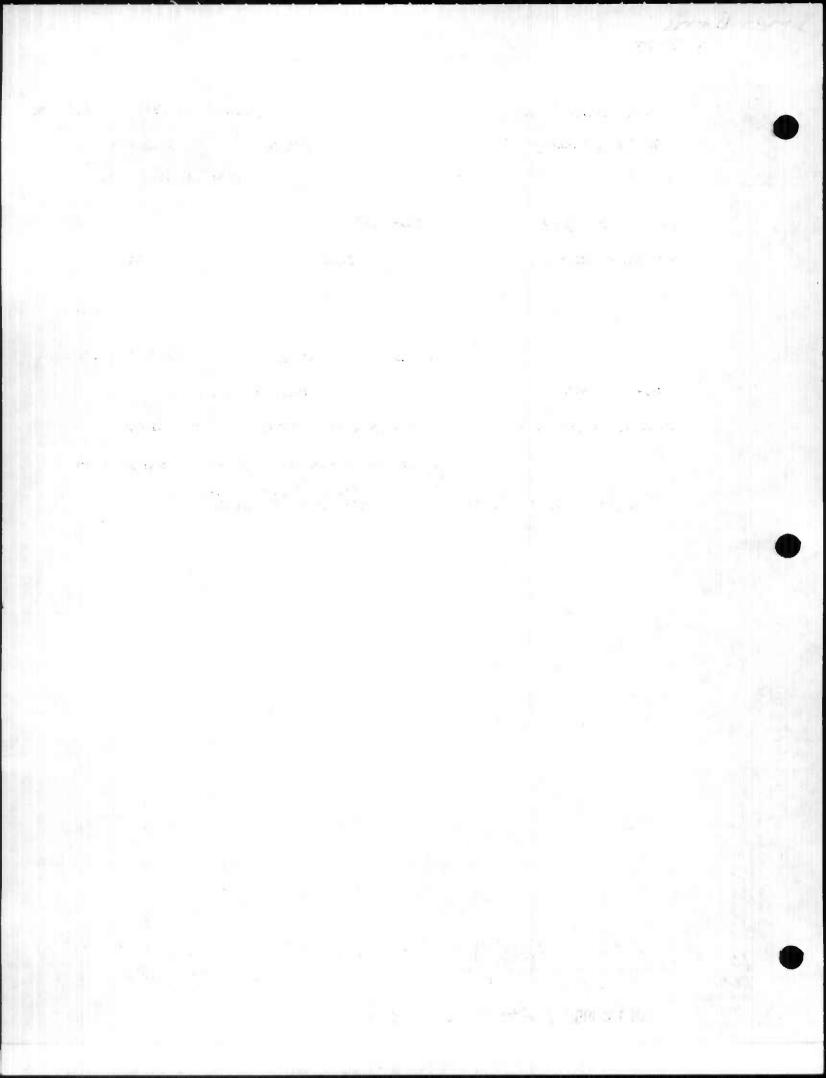
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth **Physician** Month Dey 1999 Year 10, 8:26 pm Jan. JAMES JOSEPH BURNS /Medical 4a. Facility Name (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND NURSING CENTER CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 15, Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. lest birthday) **Funerai** 1**X**) M 2□ F Days Hours Yrs Director 73 723-09-1182 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director Cumberland 1 X Yes 2 □ No Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 "natural", or Items 23a 225 Emily Street 21502 USA Funeral 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedant of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indien, Black White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health end Mental Hygiene. Important: if Item 27 Is marked other than "naturel", or the Important: if Item 27 Is marked other than "natural", or the Department of the Mydical Everyna 1000. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Specify white Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant First Federal Bank 12 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Melden Sumeme) James J. Burns Nina (Eichorn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Nina M. Maphis--niece 34 Race Street; Cumberland, MD 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State Date 1 Neurlal 2 Cramation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Spacify) St. Patrick's Cemetery 01/13 Cumberland, MD 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In deeth) Last Due to (or as e consequence of) P.O. Box 68760, physician s the bune Due to (or as a consequence of): ate hes been signed by the a page 2 should be detached f Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? lokeal felerosis 1 Yes 2 No 3 Probably 4 Unknown Records, by Completed 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes an eutopsy 1 Yes certificate 1 ☐ Yes 2 ☐ No of Vital ofter death.

Olrector: After this certifications Be 25. Was cese referred to medicel axaminer? 26. Plece of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Time of Division 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated. Medical 29a. Certifier completely To the within 2 To the 29b. Signature end title of certifier 29d. Date signed (Month, Dev. Year) 12 31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signature State JAN 1 2 1999 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death Day Month Yaar JANET BAILEY 9:15 PM JANUARY 1999 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick Frederick Memorial Hospital 8. Data of Birth (Month, Day, Year) Feb 24, 1912 If Under 1 Yaar | If Undar 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Days Months 1 M 2 F Hours 226-84-7011 86 Virginia Usual Rasidence of Dacedani 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Maryland Frederick Mount Airy 1 Yas 2 No 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 13501 Kimberly Court 21771 U.S.A. 12. Was Dacedant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates: 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, atc. 1 □ Navar Married 2 Narried White 1 ☐ Yas 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Dacedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 10 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Father's Nama (First, Middla, Last) Percy **GUYNN** A Mary E KARN 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant'a Name/Ralationship (Type, Print) James S. Bailey, Husband 13501 Kimberly Court, Mount Airy, Maryland 21771 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 BRemoval from State Cloumbia Gardens, Jan 4, 1999 Arlington, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 22, Nama and Addrass of Facility Keeney & Basford P.A. Funeral Home M00706 Kothem 106 East Church Street, Frederick, Maryland21701 and, or complications that caused the death. Do not entar tha moda of dying, such as cardiac or respiratory arrest, at List only one cause on each line. 23a. Parts. Enter the diseast Approximate Interval Batween Onset and Daath Immediata Causa (Final disaasa or condition rasulting in daath) Jepsis Dua to (dr as a consequence of): Myelodysplasia Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury Dua to (or as a consaguance of) Dua to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I.

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itema 23a or: any Injury or other traumatic event, the Medical Examiner must be an ence.

Director

Funeral

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Completed

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physician and the burial-transit 88 attending p signed by the a should should has 36.2 is certificate has After this To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After th completely filled in by the funeral

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician:

Physician/Medical Examiner

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that initiated avants rasulting in daath) Last

1 Yes 2 No 3 Probably 4 Unknown

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24b. Wara autopsy findings available prior to complation of causa of daeth? 24a. Was an autopsy 2 No 1 □ Yas ZANo 1 ☐ Yas

Hospital: 2☐ ER/Outpatient Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Spacity) 27. Mannar of Death 28d. Dascribe how Injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Cartifiar (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. Licansa number

MO 5160

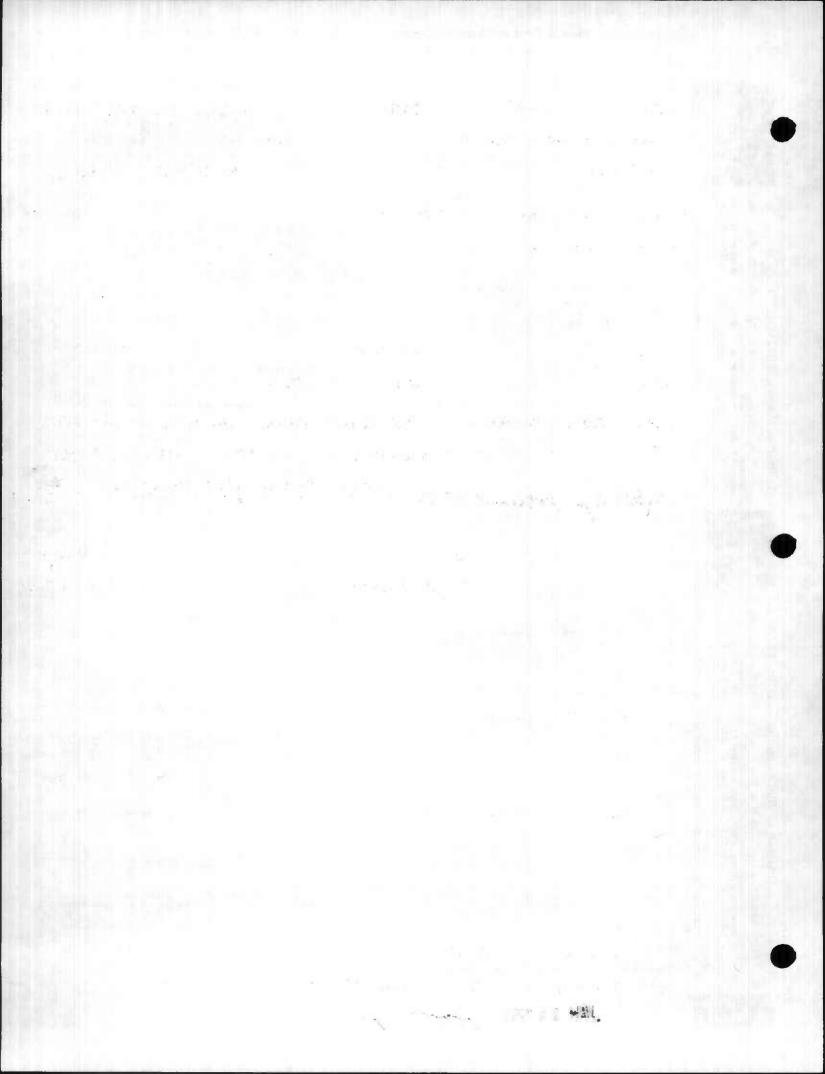
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MD 10 ~ 30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

0 4 1999

Aue Suite MD 1475 204 Tanau 31. Data filed (Month, Day, Yaan) 32. Ragistrar' Signatura

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien O

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	/Medi		Elsie Marie C							January	1 100		5:53 a.m.
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	Funeral Director		5. Social Security Number 220–26–8151 Usual Residence of Decede		6ex I□M 2ሺF	Age (In yrs. 88	iest birthday) Yrs.	If Under 1 Yeer Months Deys		. (Month, D	rth ey, Year) L4, 1910	9. Birth Cou East	pplace (State or Foreign Intry) ton, MD
	yland	ctor	10e. State 10b. Co		ty, Town or Lo	cation				T	10d. Inside City Limits		
	lore, Maryland 21215-0020 ges 1 and 2 should be filled within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exercises must be notified at		Maryland Kent Kennedyville					ille					1⊠Yes 2□No
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21215-0020 within 72 hours after degree.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☑ Widowed 4 ☐ Divo		12. Wes Deceder Armed Forces 1 Yes 24 If Yes, Give Yeer or Dates	no No	15	Was Decedent of I Yes, specify Cub I ☐ Yes 2X No	Hispenic Origin? (Spen, Mexican, Puer Specify:	Specify Yes or Note 1	Specify	k, White,		
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9	filed with Hygiene. other than		17. Fether's Name (First, Mid	idle, Lest)		walti	ess	18. Mother's Na	me (First, Middle	, Maiden Sumem		Lant
Maryland	should be nd Mental marked o	To Be	William White	ley	Pardee				Laura A			7	
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	s 1 and 2 of Health a item 27 is		Peggy Thompso	n			28043	Creamer	y Street	, Kenned	dyville,	MD	21645
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Ë	. Pages iment of I lant: If ite lury or or		4 Donetion 5 Other	r (Specif	y)	Ch	nester	Cemetery		1/9/99	./9/99 Chestertown, Marylan		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other ODCs.		21. Signeture of Funeral Ser	10	111 -	C	Fo	Name end Addre	olfonhai	n & Newr	nam Fune	ral F	Home, P.A.
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	Physician / /Medicai		tmmediete Ceuse (Finel		1.				rdiova.				Criser end Death
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	To the Hospital or Attending Physician: while 24 hours lefte deals self deals To the Funeral Director: After this certified completely filled in by the funeral director,	edical	(Check only 2 Med	cat Exam	Iner: On the basis of end menner s	of examine	tion end/or Invi	estigation, In my o	opinion, deeth occu	irred et the time,	date and pleca, e	nd due to	o the cause(s)
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Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** Dorothy Amanda Cahall 3, 1999 January 12:00 p.m. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 103 Brookmeadow Apartments Chestertown Kent H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)

Months Days Hours Min. July 24, 1938 5. Social Security Number 9. Birthpiace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funerai** 1 M XXF Yrs. Director 60 Pennsylvania 222-24-2748 Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c, City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director XIX Yes 2 No Maryland Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 103 Brookmeadow Apartments or items 23a 21620 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White by Specify: 3 ☐ Widowed 4 ☐ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 10 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 end 2 should be nent of Health end Mental int: If itam 27 is marked or Willard Thomas Cahall Amanda May Clough 19e. Informant's Neme/Relationship (Type, Pringten-19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jennie Adkins Burris/Sister 2015 Millington Road, Millington, Maryland 21651 other 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from Stete permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Templeville Cemetery/January 7, 1999 Templeville, MD 21. Signature of Fyneral Service Licer Fellows, Helfenbein & Newnam Funeral Home, P.A. PO Box 270, Millington, Maryland 21651-0270 that blused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, use of the line. r the disease, or comp heart failure. List only one **Physician** /Medicai Immediate Cause (Final e BRS disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): The lew requires that the death certificate be execu Records, P.O. Box 68760. Physician/Medical the been signed by the ette should be detached for Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy page 2 certificata 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital Hospital or Attanding Physician: 25. Was ceee referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home Certification: To 5 Residence 6 □Other (Specify) this 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturai 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident after death filled in by the 6 ☐ Could not be determined 3 ☐ Sulcide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours 1 certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner stated. Medical 29a. Certifier (Check only To the Vithin 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 8 Name and address of person who completed cause of death (Item 23a) (Type, Print) 216200 31. Dete filed (Month, Dey, Year) State JAN 0 7 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death January 4, 1999 Month Mary Elizabeth Moffett Crew 7:55p.m. 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Daeth 112 Washington Ave (Residence) Chestertown Kent If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) May 2, 1908 Birthplace (Stete or Foreign Country) 1□M 2 F Days Months 217-25-8227 90 Kennedyville, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Maryland | Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 112 Washington Ave 21620 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2000No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: Specify: White 3 XWidowad 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Ownhome 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumema) Walter Moffett Mary I. Cooper 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Donald Howard Crew/Son 112 Washington Avenue, Chestertown, Maryland 21620 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC 1/5/99 | Stevensville, MD 22. Nama and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part1. Enter the disaase, or complications that caused the death. Do not anter the moda of dying, such as cardiac or raspiratory arrast, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) CONGESTIVE HEART FAILURE Due to (or as e consequence of): VALVULAR CARDIOMYOPATHY Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated events resulting in deeth) Last Dua to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown PANCUTOPENIA 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was cese referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 ☐ Nursing Homa 5 Residence 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 TYes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Examiner P.O. Box 68760. of Vital Records, Division

The law requires that the death certificate be executed anding physician and use es the bunel-transit 8 page 2 should certificate Attanding Physician: spital or Attending Phys nours efter death. neral Director: After this y filled in by the funeral di this To the Hospital o within 24 hours eff To the Funeral DI completely filled in

27. Manner of Death (X) Natural 2 Accident 3 Sulcide 4 Homicide

> 29e. Certifier (Check only one)

Physician/Medical Examiner þ Completed Be Certification: To Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items

permit. Pages 1 end 2 should be filed within 72 hours efter Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than "natural", or ite any finlury or other traumatic event, the Medical Examina

Physician /Medical

Baltimore, Maryland 21215-0020

event, the Medical Examiner must be nutflied at

Director

Funeral

by

Be Completed

2

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner es steted.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Yaer)

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, Maryland 21620 31. Date filed (Month, Day, Yeer)

State Registrar

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Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedenf's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** RACHEL COHEN 01.05.1999 9:31 AM /Medical 4a Facility Name (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys 1□M 2√F 86 Yrs. 215.76.2584 Director ISRAEL 03.02.1912 Usuel Residence of Decedent 10a. Sfate 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 3 No Director MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herns 23a 5 CANDYTUFT COURT 20853 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 20 No tf Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married natural', or 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: if item 27 is marked other that any hijury or other traumatic event, the page. HOMEMAKER **OWNHOME** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) YEHUDA KATZ EVA GOLDSTEIN 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ZIVAN COHEN/SON 10701 TARA ROAD, POTOMAC, MARYLAND 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 20a. Method of Disposition 1 Suriel 2 ☐ Cremetion 3 ☐ Removel from Stete JUDEAN MEMORIAL GARDENS 4 ☐ Donetion 5 ☐ Other (Specify) 1.8.99 OLNEY, MARYLAND 22. Name end Address of Fecility
EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signefure of Funeral Service Licens 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximete Intervet Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. **Physician** immediate Cause (Final disease or condition resulting in death) /Medical CARDIOPULMONARY ARREST Examiner Due to (or es e consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lesf Due to (or as a consequence of): CORONARY ARTERY DISEASE Physician/Medical Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 3 Probably 4 NUnknown 1 Yes 2 No by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatienf 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred Certification: 1X Natural 1 TYes 2 No 2 Accident

physicien end s the bunal-trensit certificate To the Hospital or Atlanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Baltimore, Maryland 21215-0020

5 Pending investigefion 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

3 ☐ Suicide 4 Homicide

29a. Certifier (Check only one) 6 Could not be determined

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 CCertifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete and plece, and due to the cause(s) end menner steted.

29b.	Signeture and title of certifier	
	1/26 - C/h	1
	Manage 402	has

29c. License number 040453

29d, Dete signed (Month Dav. Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

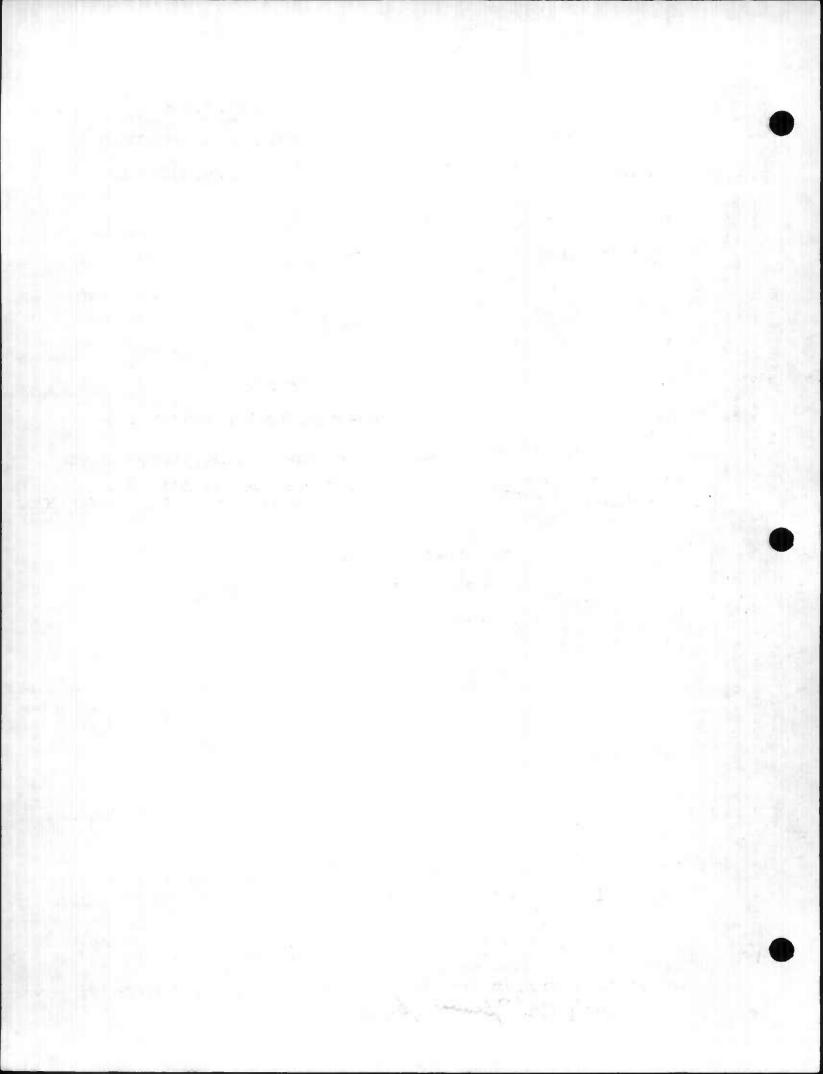
VICTORIA L. THORNTON, MD 31. Dete filed (Month, Dey, Year) State **JAN 1 1**

32. Redistrer's Signeture

8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND

Registrar

edicai



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q 0 151, 2

		Otato of Maryland		te of Death		Reg. No.	01342						
Physician	1. Decedent's Name (First, Middle, Las Walter		ombe		2. Date of De Month Janua	ath Day Y	3. Time of Death						
/Medical Examiner	4a Facility Name (If not institution, give	4c. County of	of Death										
Funeral Director	5. Social Security Number 6. Se	7	Spital last birthday) If Und Yrs. Months	er 1 Year If Under 24 Hrs	8. Date of Bir (Month, De March		e George's Birthplace (State or Foreign Country) ashington, DC						
p s	Usuel Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Location				10d. triside City Limits						
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vith the Mar to 28s-f a be notified Director	10e. Street and Number	201869		ip Code		10g. Citizen of Who	at Country?						
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d 21215-0020 filed within 72 hours after death with the Maryland Hygiene. there then "natural", or thems 23a or 28a-f show ent, the Medical Exeminar must be notified at 5 completed by Funeral Director.	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U,: Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	Armed Forces? If Yes, specify Cuban, Mexican, Puerting 1 ☐ Yes 2 ☒ No I ☐ Yes 2 ☒ No Specify:				American Indian, White, etc. White						
1 21215-0020 ed within 72 hours at ygiens your than "natural", or t, me Medical Exam Completed by F	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		uat Occupation rork done during most of wo use retired)	rking	16b. Kind of Busin							
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Marylan d 2 should be the and Mental T is merked to treumatic every treumatic every to Be	19a. Informent's Name/Relationship (7	er, City or Town, St	ete, Zip Code)										
	Helen R. Coombe	(wife)	3508 Full	erton Street	, Beltsv	ille, MD	20705						
or other	20a. Method of Disposition 1 🗆 Burial 2 🖾 Cremetion 3 🗀	~	tace of Disposition (N emetery, cremetory or	ame of other place)	Date	20c. Location - Ci	ty or Town, State						
altimo nit. Page antment ortant: if injury or	4 Donation 5 Other (Specify				1/9/99		ia, Virginia						
Baltimore, pemil. Pages 1 at Department: If them eny injury or other ance.	21. Signature of Funeret Service Licensee 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901												
Control of physician and the property of physician and the purial-transit as the burial-transit and the purial-transit and the purial-tra		hage ulcers		triterval Between Onset and Death									
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Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, fector)		on (Street and Number or Rurel Route Number, Town, Stete)								
he Hospital in 24 hours he Funeral pietely filled	29a. Certifier (Check only one) 12 Certifying Phy	rsician: To the best of my know iner: On the basis of examinati and manner stated.											
Methin Me	29b. Signeture end title of certifier			9c. License number		29d. Date signed (Month, Day, Year)						
	orshsadi.	m 0		D 53411		116199							
10	30. Name and address of person who o	completed cause of death (Item 3060 Mitchell		=103 B	onie	MD	20716						
State Registrar	31. Date filed (Month, Pay, Year) 199	9 32. Degistrar's Signat	ture B. Ap	rocks									

See Link

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State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death O7 .TAN **Physician** THOMAS CORBMAN 1999 12:26 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LAUREL COMM. Hospital LAUREL PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 1 € M 2 □ F Deys Months 577-50-2913 62 Yrs. Director 07 1936 WASHINGTON. D.C. Usual Rasidance of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. inside City Limits real be retified at 1 Tas 2 No Directo MARYLAND PRINCE GEORGES ADELPHI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1509 QUINNWOOD 20783 ST. UNITED STATES Funeral death al Hygiene. Jother than "natural", or Hema Savent, the Madrical Exercitor in Reme 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian 11. Marital Status Black, Whita, atc. permit. Pages 1 end 2 should be filed within 72 hours after to Department of Health and Mentel thygiene. Important: If them 27 is marked other than "natural", or her any Injury or other traumetic event, the Medical Exercities. 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ♥ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondery (0-12) Collega (1-4or 5+) 12 SALES REPRESENTATIVE PUBLISHING 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be HERMAN ROSIN ALMA BRIGGS 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) ANDREW CORBMAN SON 47323 STERDLEY FALLS TERRACE, STERLING, VA 20165 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 2000 Barial 2 Cremation 3 A moval from State JUDEAN MEMORIAL GARDENS 01/12/99 OLNEY, MD 4 Donation S Dthar (Specify) aturno of Fa ingel Service Licent 22. Nama and Addrass of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Part 1. Entertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lat only one cause on each the Approximata Interval Between Onset and Death **Physician** mediate Cause (Final ease or condition julting in death) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate has 1 ☐ Yes 2 E NO 1 Yas 2 No Hospital or Attanding Physician: 24 hours after death. the funeral director, 25. Wes casa rafarred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yas 2 No 1 ☐ inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Aftar this 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28d. Describe how injury occurred 5 Panding investigation 1 Natural s after death. 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datermined 28a. Place of Injury - At home, farm, atreet, fectory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner stated. 29e, Cartifier completaly (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifiar 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 30 Q ered 'e

DHMH 16 Rev 6/95

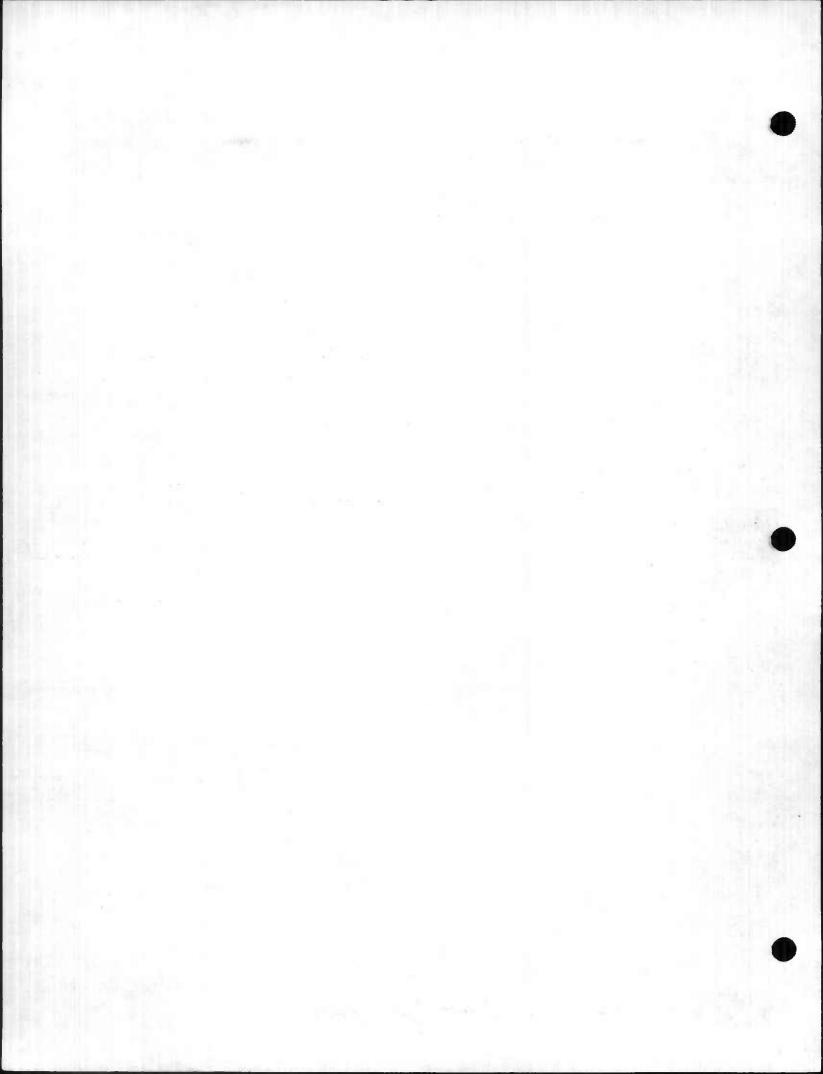
State

Registrar

31. Data filed (Month, Day, Year)

JAN 1

32. Registrar's Signatura



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Corkum Merrill Gordon Y 10 1999 4c. County of Death JANUARY 10 /Medical 4e Fecility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES PT WASHINGTON WASHINGTON HOSPITAL if Undar 24 Hrs. 8. Date of Birth (Month, Day, April 30, If Under 1 Birthplece (State or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) **Funeral** 1⊠M 2□F Yrs 56 281-38-2330 Massachusetts Director Usuel Residence of Decedent deeth with the Marylend 10c. City, Town or Location 10d. Inside City Limits I Hygiene. other than "natural", or items 23e or 28e-f ahow rent, the Medical Eventiver must be notified at 1 ☐ Yes 2 No Directo Oxon Hill Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20745 572 Wilson Bridge Drive, #C-2 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indien, Bieck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Pages 1 and 2 should be filed within 72 hours efter nent of Heelth end Mental Hygiene. int: If Ham 27 Is marked other than "natural", or Ha 1 Never Marriad 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White by 3 Widowed 4 Divorced ed Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementery/Secondary (0-12) College (1-4or 5+) Court Reporting Company Court Reporter 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Merrill Gordon Corkum, Sr. Alice Short 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Audra T. Welch (daughter) 38487 Arlington Drive, Mechanicsville, MD 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Page Department of Important: If any Injury or once. Chesapeake Crematory 1 - 12 - 99Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Nama and Addrass of Fecility
Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete intervel Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical . ARTERIOS CUEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or es e consequence oi) Examiner The law requires that the death certificate be executed attending physician end for use es the bunal-transit Sequentielly list conditions, if eny, laading to immadiate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequence of) signed by the a d be deteched t Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ETHANOL þ been si 24b. Were eutopsy tindings avellable prior to 24a. Wes en eutopsy Completed completion of cause of deeth? ils certificate hes I director, page 2 s 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case reterred to medical examiner?

1 Yes 2 □ No Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dev Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Naturel 5 Pending investigation 1 Yes 2 No To the Hospital or Attendia within 24 hours efter death. To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier 🗀 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted. (Check only one) igetion end/or investigation, in my opinion, death occurred et the time, dete end plece, and due to the ceuse(s) 2 Medical Examiner: On the basis of exa and mather stated. 29b. Signatur 29c. License number 29d. Dete slaned (Month, Day, Year) 30. Name end eddress of person who complete cause of death/(Itugi 23a) (Type, Print)

300

HOSPITAL PRIVE, CHEVERLY, MARYLAND

State Registrar MARIO

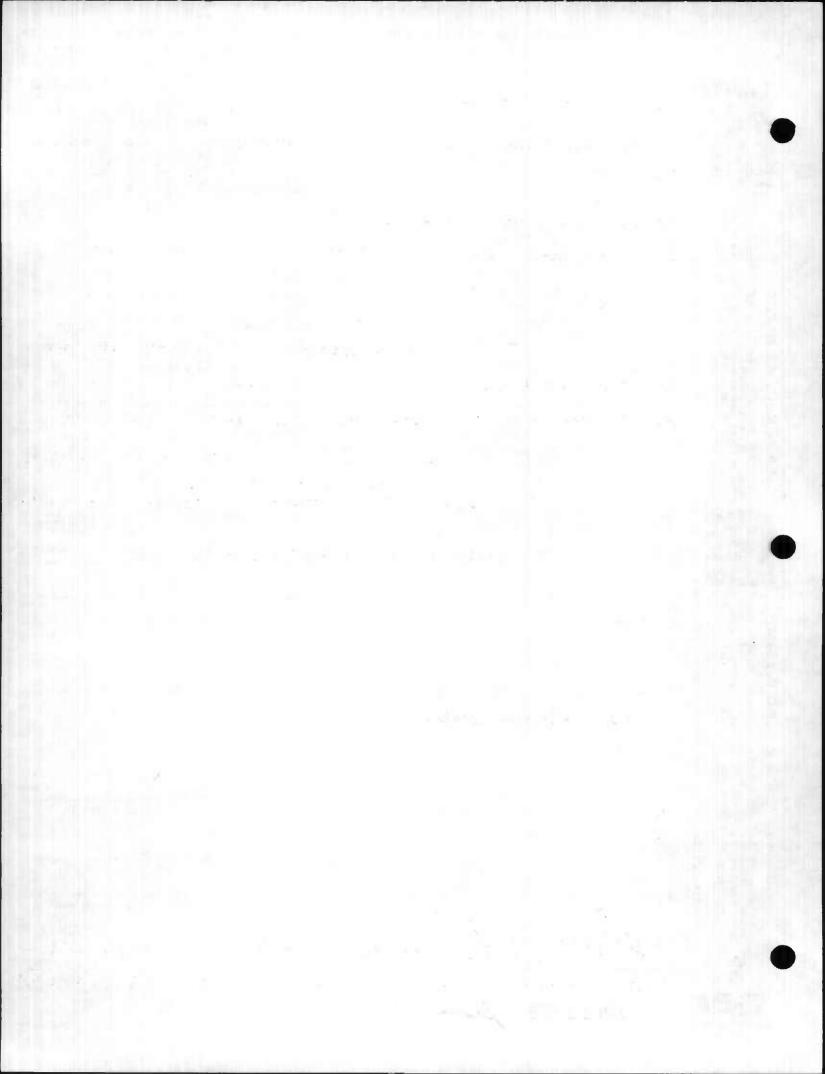
31. Dete filed (Month, Dey, Year)

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JAN 1 2 1999

32. Registrer's Signeture

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death 1999 VIOLA F. COOPER 7, Jan. 5:00 pm 4a. Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death CUMBERLAND
If Undar 24 Hrs.
Hours Min.
8. Data o 123 COLUMBIA STREET ALLEGANY 5. Social Sacurity Number If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) Months 1□M 20F Days Yrs 216-76-2177 Usual Rasidanca of Decadant WV 78 Jun 5, 1920 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No MD Allegany Cumberland 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 123 Columbia Street USA 21502 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1√2 Navar Marriad 2 Marriad 1 ☐ Yas 2 No Specify: 3 Widowad 4 Divorcad Specify white Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantery/Secondary (0-12) College (1-4or 5+) 12 N/A None 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Hiram Cooper Katie (nmn) 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) Virginia King--friend 123 Columbia Street; Cumberland, MD 21502 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cametery, cramatory or other place) 20c. Location - City or Town, Stata Data 1 □ Burial 2 □ Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Other (Spacify) Indian Mound Cemetery 01/11 Romney, WV 21. Signature of Funeral S 22. Name and Addrass of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Part 1. Entar tha disaasa, or complications that caused the shock, or haart failura. List only on a causa on as the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Immediata Cause (Final disaasa or condition resulting in daath) uk yrs Arteriosclerotic Heart Disease Dua to (or as a consequence of): Sequantially list conditions, if eny, laading to immadiata cause. Enter Undarlying Cause (Disaasa or Injury that initiated events rasuiting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Urosepsis 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy GI reflux with prg tube insertion 1 Yas 200 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical examinar?

1 X Yas 2 No 26. Placa of Daath (Check only ona) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Rasidanca 8 Othar (Specify) 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Invastigation 1 Yas 2 No 2 Accidant 6 Could not ba 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide 29a. Cartifier

The law requires that the death certificete be executed P.O. Box 68760, Records. Division of Vital Hospital or Attending Physician: death.

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Examiner Physician/Medical by Completed Be Certification: To

Physician

/Medical

Examiner

Director

Funeral

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the

death

72 hours efter

Baltimore, Maryland 21215-0020

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"natural",

filed within 7.
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Pages 1 end 2 should be filed nent of Health and Mental Hygint: If Item 27 is marked other

nt of Health a : If Item 27 is or other trau

permit. Page Department of Important: If any injury or once.

Physician /Medical

Examiner

To the Hospital or Attendir within 24 hours efter death.

To the Funeral Director: A completely filled in by the fi

8

State Registrar

Medical

(Check only one)

29b. Signatura and title of certifian

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the causa(s) and mennar stated.

29c. Licansa number D09157

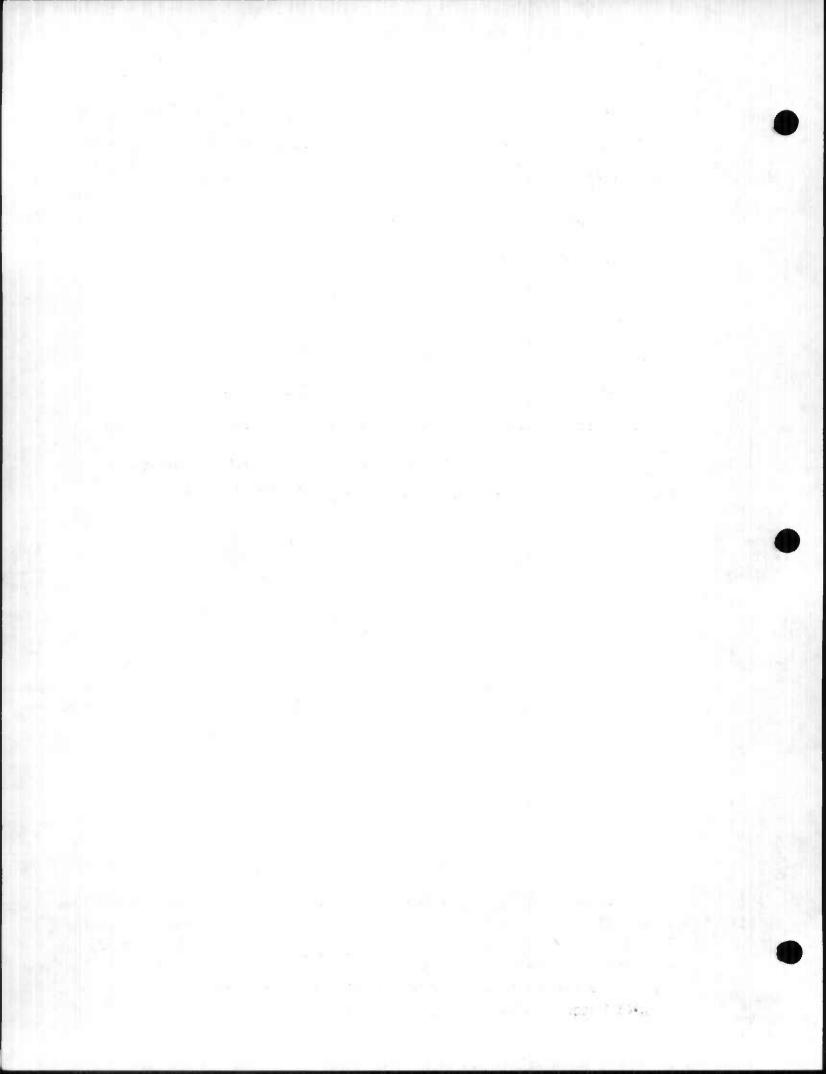
29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed causa of deeth (Item 23a) (Type, Print)

Dr. Paul Snow; 124 W. Third Street; Cumberland, MD 21502
31. Data filed (Month, Day, Year) 82. Ragistrar's Signature. 82. Ragistrar's Signature

JAN 1 1 1999





Please Type or Print in Black Indelible Ink. Assure Ali Coples Are Legible.

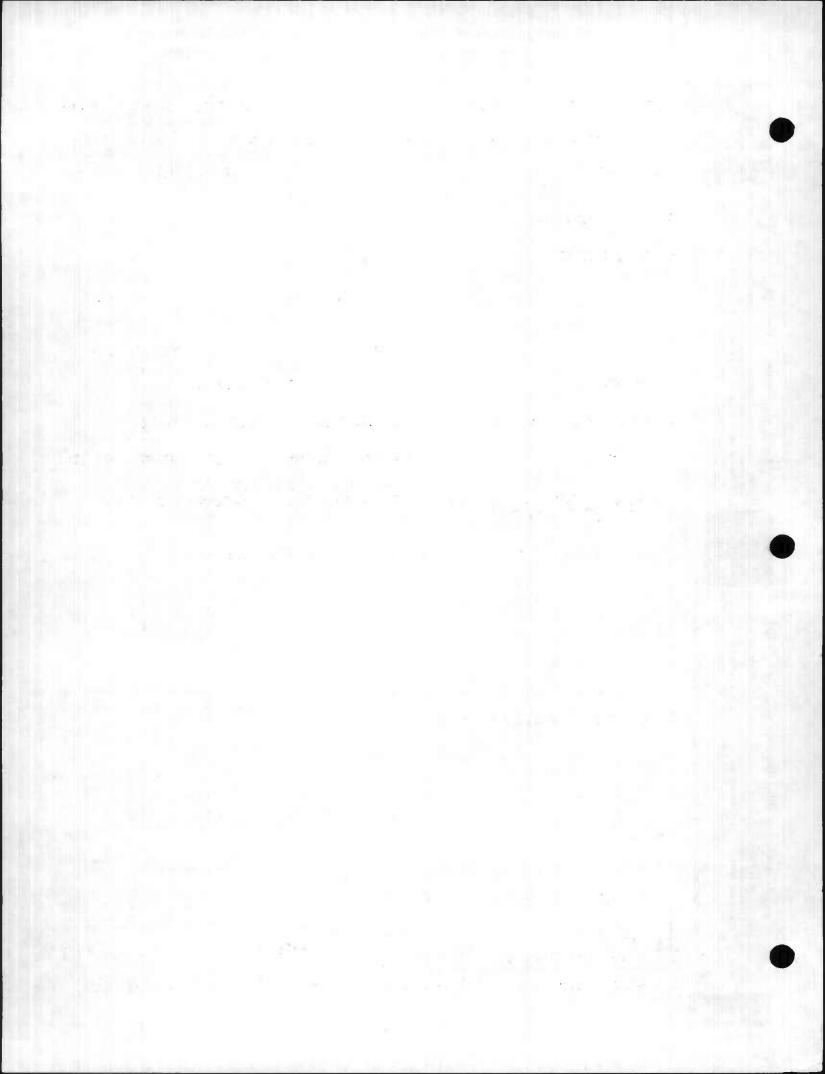
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Funeral Director	5. Social Security Num 215-26-7		x □M 2∑F 7.	Age (In yrs. le	ast birthday) Yrs.	If Under 1 Ye Months De		24 Hrs. 8. Dete of (Month, NOV . 1	Birth <i>Dey, Year)</i> 6,1927	9. Birthplece (State Country) MARYLAND	or Foreign		
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5-0020 72 hours efter deeth with the Maryland naturel; or items 23s or 28s-f show dies Example to a collect standard by Funeral Director	11. Maritel Status 1 Never Married 3 Widowed 4		12. Wes Decede Armed Force 1 Yes 24 If Yes, Give Yeer or Dete	es? If Yes, specify Cuban, Mexican, Puerto Ric					ify Yes or No- can, etc.) 14. Rece - American Ind Bleck, White, etc. Specify: WHTTE				
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Baltim permit. Pag Department Important: I any Injury o	21. Signeture of Funeral Service Licentees UPCHURCH FUNERAL HOME, P.A.												
	202 GREENE ST., CUMBERLAND, MD 21502 23a. Pert1. Enter the officease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between												
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P.O. hat the bd by the detached	DIABETE		ditions contributing to death but not resulting in the underlying ceuse given in Pert t. [MELLI TUS						23b. Did tobacco use contributa to the cause 1 Yes 2 No 3 Probably 4				
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State Registrar

ROBUSTANO N 31. Dete filed (Month, Day, Year) JAN 04 1999

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth 3. Time of Death Month Day Yaar **Physician** 8, 1999 4:00 AM Eleanor Francis Jaquith Cummings Jan. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Queen Anne's 100 Bryans Channel Queenstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (Steta or Foraign Country) 7. Aga (In yrs. lest birthday) **Funeral** Months Days 1□M 2以F Yrs. 95 April 12, 1903 Massachusetts **Director** 008-28-4474 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Merylend Department of Health end Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, or a Medical Examinating must be marked once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside Cltv Limits 1 ☐ Yes 2 ☐ No Directo Queen Anne's Queenstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 100 Bryans Channel 21658 Funerai 14. Rece - American Indian, 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 11. Marital Status Black, White, atc. 1 ☐ Yes 2 ☒ No If Yes, Giva Yaar or Dates: 1 ☐ Nevar Marriad 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify. Specify: White þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self. Homemaker 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Ethel Cummings John S. Jaquith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 100 Bryans Channel, Queenstown, MD 21658 David Warren Cummings Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Dete Jan. 8, 1999 1 ☐ Burial 2 M Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Ctr. LLC. Stevensville, MD 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home P.A. Shamrock Road, Chester, MD at caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, on each line. 23a. Part1. Enter the disease or complete shock, or heart failure. List only one Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical cean Examiner Physician/Medical Examiner ettending physician end for use es the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest Due to (or as e consequence of) P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 signed b Division of Vital Records, by 24b. Were autopsy findings evellable prior to complation of causa of death? been sig 24a. Wes en autopsy performed? Completed hes is certificate ha 1□Yes 2E No 1 Yes 2 No a Hospital or Attending Physician: 24 hours after death.

• Funeral Director: After this certificalety filled in by the funeral director, p 25. Was cese referred to medicel exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation ector: 2 Accident 6 ☐ Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. 29e. Certifier edicai To the Hosp within 24 hou To the Fune completely fi 2 Madical Examiner: On the basis of examinetion end/or Investigetion, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner stated. (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of certifian 29c. License number

Jan. 8, 1999

H - 42587

2540 Centreville Rd., Centreville, Md. 21617

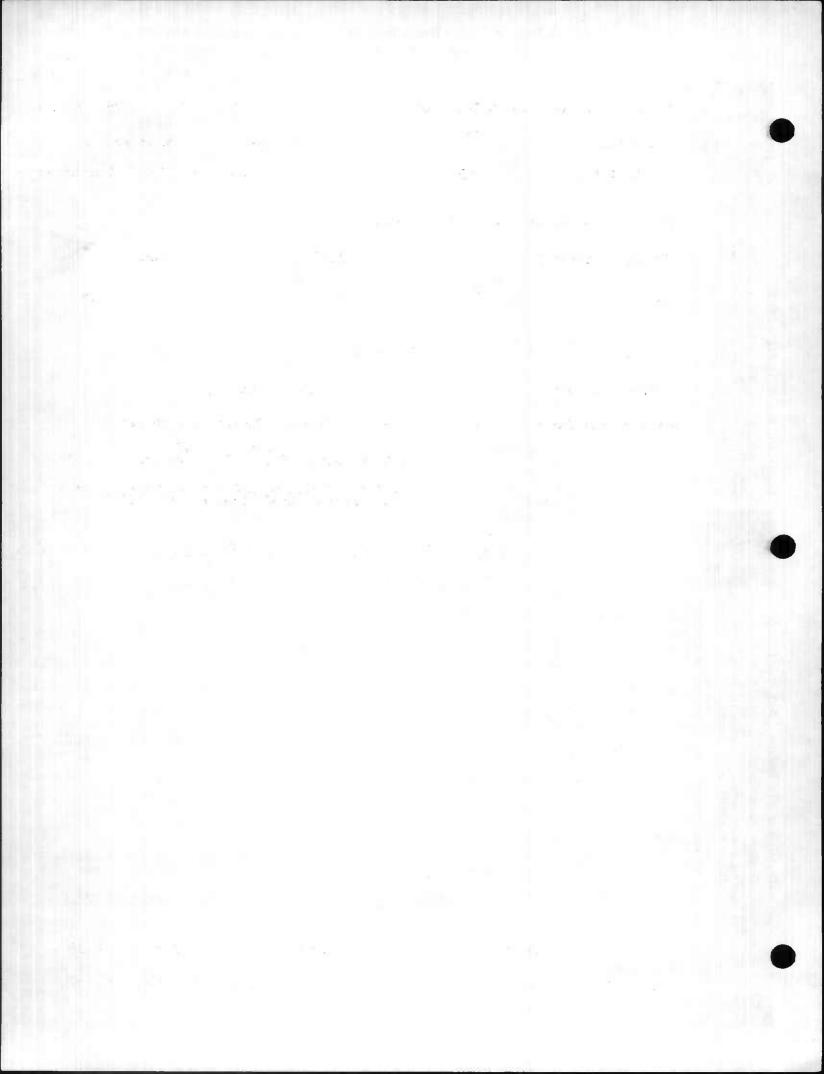
State Registrar Russell

31. Dete filed (Month, Dey, Year)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture

Schilling:



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth January 1, 1999 **Physician** Mellie Lee COOLEY 7:30 AM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 22320 Old Hundred Road Barnesville Montgomery 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 9. Birthplece (Stete or Foreign **Funeral** 1 M 2 TYF Months Deys Hours 219-12-2509 Director July 24,1911 Maryland Usual Residence of Decedent the Manylend 10e. Stete 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Exertines may be notified at 10d. Inside City Limits Maryland Director Montgomery Barnesville 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 22320 Old Hundred Road 20838 U.S.A. Funeral death Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ÆX No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Rece - American Indian Bleck, White, etc. Pegas 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or ite 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3℃Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Luther MCDONOUGH Mary Etta RENNTCK 2 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Mr. Charles D. Cooley, Son 22331 Old Hundred Road, Barnesville, MD Baltimore, 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete permit. Pegas
Department of H
Important: If ite
any Injury or of XX Burial 2 Cremetion 3 Removal from Stete Mount Olivet Cemetery, Jan. 5, 1999 Frederick, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Keeney and Basford P.A. Funeral Home MO0255 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, MD shock, or heart failure. List only one ceuse on each line. 21701 Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Finei diseese or condition resulting in deeth) /Medical Cerebrovasalor accident 27/1 **Examiner** Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificete be axecuted Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Lest and burial-tran Due to (or es e consequence of): the Due to (or as e consequence of): for use as Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypert-nsim by 8 24b. Were eutopsy findings eveileble prior to Completed 24e. Wes en autopsy performed? completion of ceuse of deeth? has certificate 2000 1 Tes 1 Yes 2 No Attending Physician: Be 25. Wes case referred to medicei exeminer? 26. Piace of Deeth (Check only one) 10 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred After t ours after dean. 5 Pending Investigation atural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours a To the Funeral D completely filled in Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Division of Vital Records, P.O. Box 68760,

State Registrar 29b. Signeture and title of certifier

A. Austin Pearre, Jr, M.D., 300 West Ninth Street, Frederick, Maryland 21701

11. Dete filed (Month, Day Year)

JAN 04 1999 31. Dete filed (Month, Day Year) 0 4 1999

30. Name end eddress of person who completed cause of deeth (Item 234) (Type, Print)

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Sparke

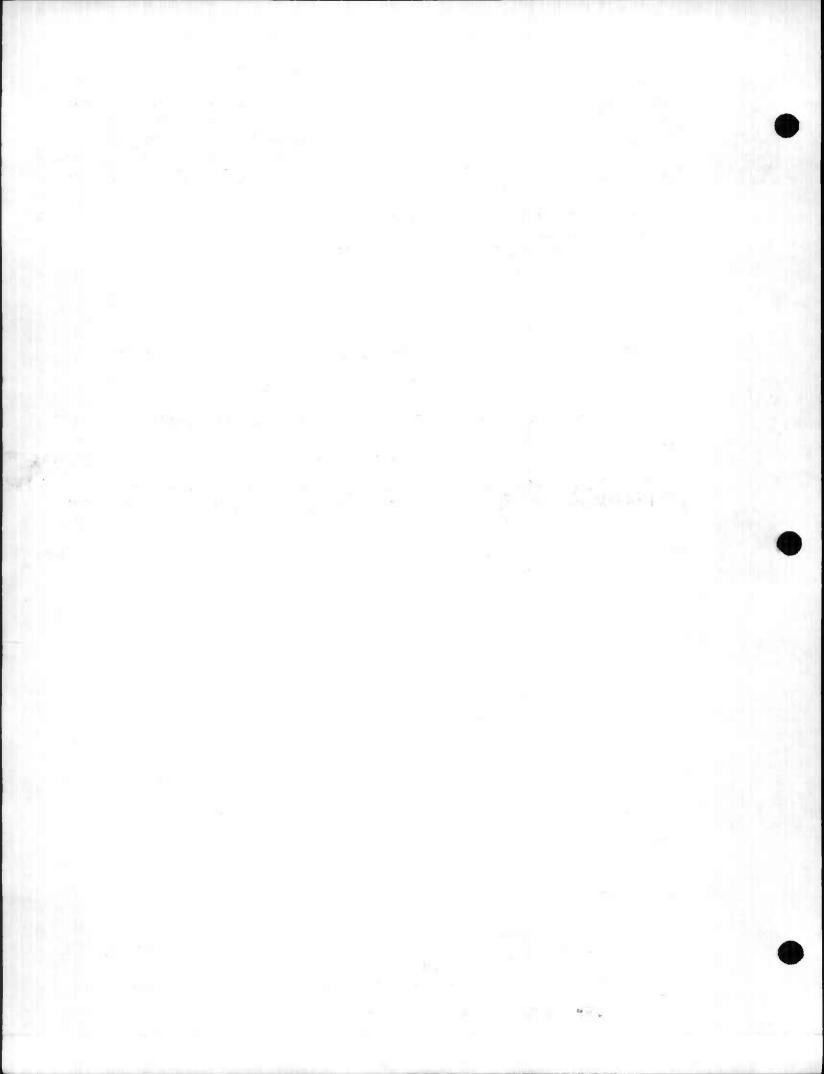
29c. License number

D09689

29d. Date signed (Month, Dey, Yeer)

January

4, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year DOBKIN 15:20 JAMES JANUTRY 1999 13 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) SCPT 9 1940 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Days Hours 1 M M 2 □ F 58 102 32 1515 Yes Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits **BETHESDA** MD MONTGOMERY 1 ☐ Yes 2 1 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Coda 8810 FERNWOOD RD 20817 UNITED STATES 12. Was Decedent Evar in U.S. Armed Forcas? 1 Yas 2 No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, etc. 11 Marital Status 1 Nevar Merried 2 Married 1 Yas 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementery/Secondary (0-12) ATTORNEY SELF EMPLOYED 17. Fethar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Surnama) LOUIS DOBKIN ANN LAUFER 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IRMA DOBKIN [WIFE] 8810 FERNWOOD RD, BETHESDA, MD 20817 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 XBurial 2 Cremation 3 val from Stat 4 □ Donation 5 □ Other (Speed JUDEAN MEMORIAL GARDENS 1/13/99 OLNEY, MD 21. Signature of Funaral Service 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC ROCKVILLE PIKE, ROCKVILLE MD 20852 Part 1. Enter the disaasa, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or hearlfailure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GRAM POSITIVE SEPSIS 2 DAYS disease or condition rasulting in deeth) Dua to (or as a consequence of): LOBAR PNEUMONIA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown LIVER TRANSPLANT, NOVEMBER 1998 WITH 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? IMMUNOSUPPRESSIVE THERAPY 1 ☐ Yes 2 No 1 ☐ Yes 2 DENo 25. Was case refarred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicida

Box 68760.

980 P.O. Records. of Vital or Attending Physician: this funeral Affer Division r death. 24 hours after deat Funeral Director: 6 filled in Hospital To the Hosp within 24 hos To the Fune completely fi

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/Medical

Examiner

Funeral

Director

ral', or items 23s or 28s-f show Examiner must be notified at

natural, or

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any Injury or other traumatic avant, pince.

Physician /Medical

Examiner

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Physician/Medical

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Completed

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Certification: To

edical

29a. Certifier

(Check only one)

Director

Funeral

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Completed

Be

with the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

2

29b. Signatura and title of certifier

tel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29c. License number

RES-000

JANUARY 11, 1999

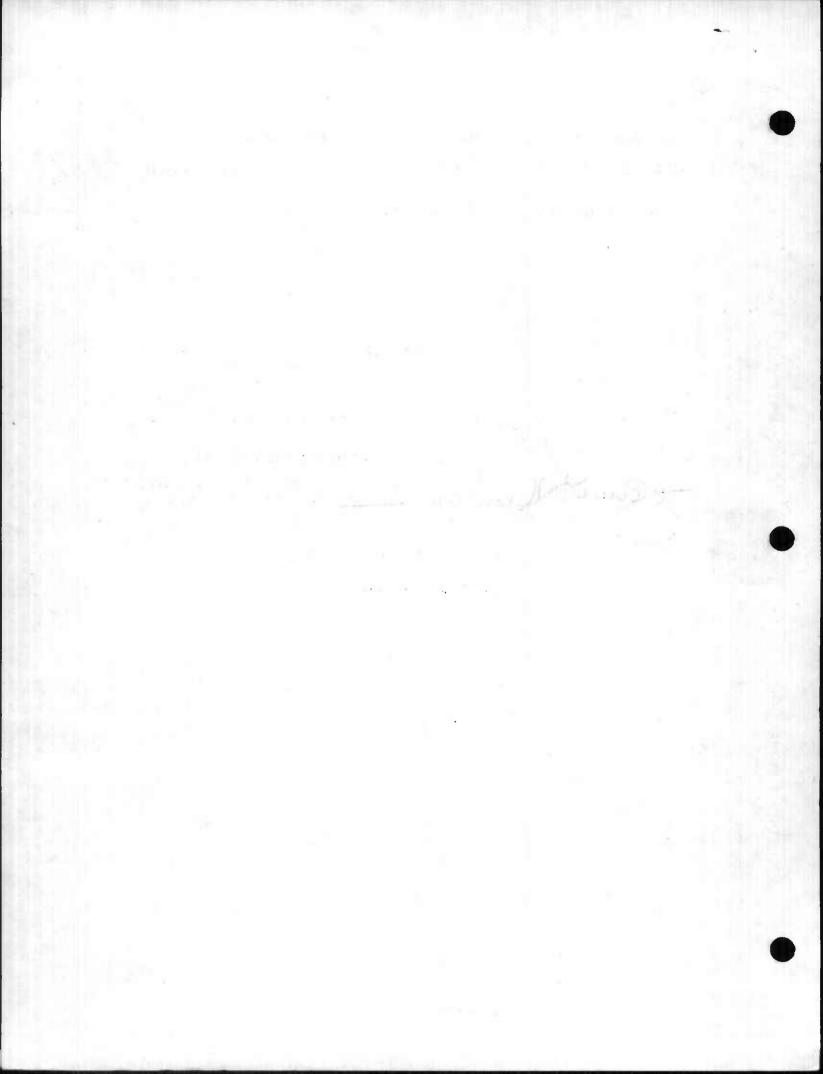
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

600 NORTH WOLFE STREET JOHNS HOPKINS HOSPITAL BALTIMORE MARY LAND

State Registrar

31. Data filed (Month, Day, Year) 1999 **JAN 13**

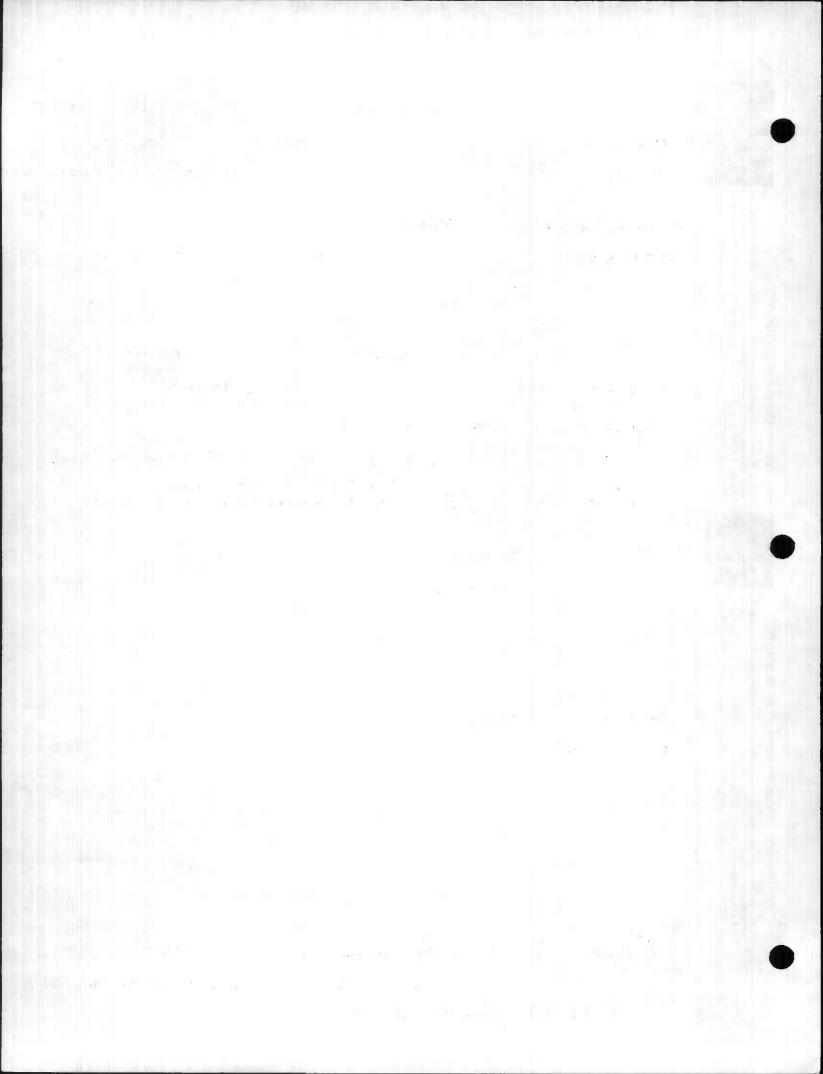
THE-HUNG EDWARD NOUYEN, 32. Ragistrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** 1999 10:25 PM Edwin Wellington Davis January 12, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner 9817 Glen Road Potomac Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Deys 1 M 2 □ F Months Hours Min. 19, 74 1924 Washington, Director Oct. 577-20-7211 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10e Stete 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highery or other traumatic avent, the Medical Examiner must be not the once. 1 ☐ Yes 2 No Director Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 9817 Glen Road 20854 United States Funeral 14. Rece - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☒ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: à 3 Widowed 4 Divorced WW II White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 4 Builder Construction 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Edwin Leslie Davis Dorothy Gongwer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Same as 10 Esther B. Davis (wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1-13-99 Chesapeake Crematory Beltsville, Maryland 22. Name and Address of Fecility
Rapp Funeral Services, P. A. 21. Signeture of Funeral Service Licensee 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting In deeth) /Medical Pneumonia Examiner Due to (or es e consequence of) Examiner Parkinsonism physician and the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): cartificata be execu Box 68760. Physician/Medical Due to (or es e consequence of): 88 980 P.O. signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 | Yes 2 No 3 | Probably 4 | Unknown requiras that Coronary Artery Disease Records, þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Was en eutopsy performed? Completed peen Diabetes Mellitus The law cartificate has page 1 ☐ Yes 2 No 1 ☐ Yes 2X No Division of Vital Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yes 2 XNo 10 Aftar this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attanding 1 Neturel 5 Pending investigation death. 1 Yes 2 No 2 Accident ector: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) after 4 Homicide 24 hours a edicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier D34742 January 13, 1999 5 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Andrew N. Umhau, M. D., 3301 New Mexico Avenue, NW, #348, Washington, DC 20016 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 14 1999 packs Registrar

DHMH 16 Rev 6/95

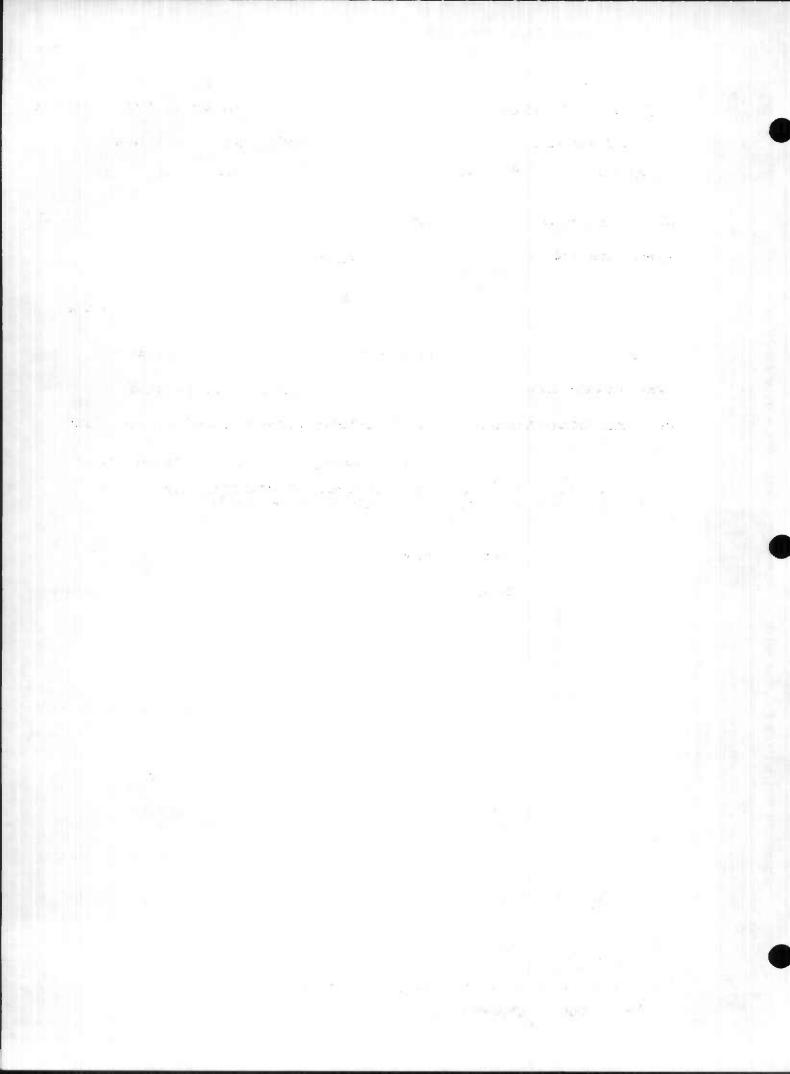


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	Di statas	Decedant's Nama (First, Middla, Last)							2. Data of Month					Daath Day Year		3. Tim	a of Death
п	Physician /Medical	Ma	ude Day								JANUA					9:2	2 PM
	Examiner	4a Facility N	lama (If not institution	on, giva stre	et and numi	ber)			4b. City, Town, or Lo				ocation of Death	eation of Death 4c. County of D			
		Sacred Heart Hospital							Cumberland					Allegany			
	Funeral Director	234-	38-8203	6. Sex	6. Sex 1 M 2 F 7. Aga (In yrs. last birthday) If Undai Months			If Undar 1 Yas Months Day		If Undar: Hours	24 Hrs. Min.	8. Data of Birth (Month, Day, Jun 1,	irth lay, Year) 9. Birthpiaca (Stata or F Country) WV			ata or Foraign	
	2	Usual Rasida	anca of Decedant 10b. Count			100.0	ity Town	or Loop	tion	-						Od Inold	a City Limits
	a Maryla Sa-f sho	MD Allegany Cumberland							1X Yas 2□No								
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020	72 hours after death with the Maryland natural; or terms 23a or 28a-f show deal Examiner must be notified at each by Funeral Director		11. Marital Status 1 Navar Married 2 Marr 3X Widowed 4 Divorced		12. Was Dacedant Evar in U,S. Armed Forças? 1 Yas 2 No If Yas, Giva Yaar or Datas:			13. Was Decedent of Hispanic Origin? (Spelf Yas, specify Cuban, Maxican, Puarto 1 ☐ Yas 2X☐ No Specify:			Prican, atc.) 14. Hace Biack, Specify:		ck, Whita,	Amarican Indian, Whita, atc.			
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215-0020	ed within 72 ho ygiene. Nor than "neturn it, ma Moucal Completed	Flamantar	(Spacify only highs y/Secondary (0-12)	ast grada co		lor 5+)		Giva kir lifa. DO	of work don NOT usa rati	na du ired)	ing most	of work	ing				
7	should be filed within and Mental Hygiene. marked other than imatic event, tra. IT to Be Comp	1	L2				Ret	ired	l Cook					Sheehe	he's Restaurant		urant
Maryland	tal Hygie d other evant, tr	17. Fathar's	Nama (First, Middla								18. Motha	r's Nam	a (First, Middla, A	Aaidan Suman	na)		
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lar	2 sho	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town															
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	Peges nent of int: If It iry or o	20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Wesley Chapel Cemetery 01/16 Points															
Balt	Departi Departi Importa any inju	21. Signatur	e of Funeral Sarvice	Licensaa	M	1,00	0		Scarpe.	II:	i Fur	nera.	1 Home,	P.A.			
		Cumberland MD 21502 23a. Parl 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death													mata		
,	Physician														nd Death		
) [Medical Examiner	Immadiata Causa (Final disaasa or condition rasulting in daath) a. A cute Myccarchal Infarelian Dua to (or and a consequence of):											Two Hours.				
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	executed in end ial-transit Examiner											7,40-7	10				
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	nes	Dr.	Harjit S	idhu	925 E	Bishop	Wals	sh F	Road Cu	mb	erla	nd M	D 21502				
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	5. Social Securit	7. Age (In yrs. I	ast birthday)	If Under 1 \		Cumb If Under 2		8. Date of Bi (Month, D			gany 9. Birthp	ace (State	or Foreign		
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riems 234 or 284-1 show the crust be notified at Funeral Director											rog. Oil	USA		yı	
Route 1 Box 194 11. Marital Status 12. Was Decedent Ever in U.S.					S. 13. V	13. Was Decedent of Hispenic Origin? (Specify Yes or No-							e - Americ		
1 Never Married 2 Married 1 Yes 2				No No	l No								Black, White, etc.		
by	X □ Widowe	d 4 Divorced	If Yes, Giv Year or D	/8		☐ Yes X☐	J No	Specify:					white		
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		nd Stalli								ice E. (Garland)					
	-	s Name/Relationship	-		19b. Mailing Address (Street and Number or Rural Route Number										
	Helen I	Middleton	daught	er	1808	Freder	ick	Stre	eet:	Cumbe:	rland	M .E			
	Helen Middleton—daughter 1808 Frederick Street; Cumberland, ME 20a. Method of Disposition 20b. Place of Disposition (Name of cometen, crematory or other place) 20c. Location - Cometen, crematory or other place)														
	1\(\text{Burlal 2 \subseteq Cremetion 3 \subseteq Removal from State} \) 4 \subseteq Donation 5 \subseteq Other (Specify) \) Mt. Tabor Cemetery \(\text{01/11} \) Spring Gap, MD														
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A.														
	M	to hova	A J.A	CALO	W:	Scarpe				Home, 1502	P.A	•			
7	23a. Part 1. Enter the discount or complication that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one may be on each line.											Approxim Intervel B	etween		
	Immediate Cause (Final disease or condition Acute leukemia										Onset and	Death			
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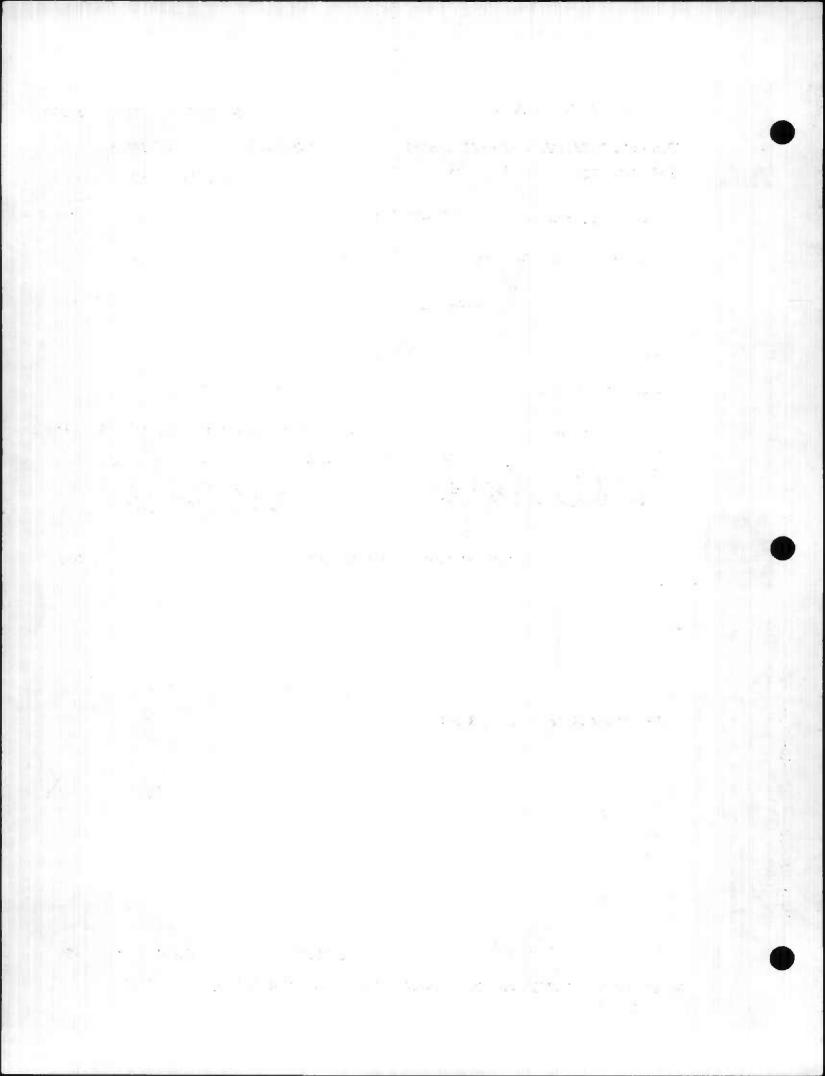
DHMH 16 Rev 6/95



A mender # 18, 7188, Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Q D I E E

	, ,		C	ertificate	of Death	,	Reg. No.	U	1000			
	1. Decedent's Nama (First, Middle, Las	<i>t</i>)				2. Date of De	ath	Vans	3. Time of Deeth			
Physician	MARY Z. D	ICKEN			JANUAR'	Day	Year 999	18:40				
/Medical Examiner	4a Facility Name (If not Institution, give				4b. City, Town, or				10:40			
Laminer												
Comment	MEMORIAL HOSPITAL 5. Social Security Number 6. Se		GENTER yrs. last birthde	v) If Undar 1 \		8. Date of Bir	ALLEC	9. Birthol	laca (Stata or Foraign			
Funeral Director		□M 21₹F 7		Months D	ays Hours Min.	(Month, De	y, Year)					
	Usual Residence of Decedent											
Idi yidiid ZIZIS-0020 2 should be filed within 72 hours after death with the Maryland and Mentel hyglene. Is marked other than "naturel", or itema 23a or 23a-f show aumatic event, the Medical Examinet man be notified at TO Be Completed by Funeral Director	10a. State 10b. County	10				10	Od. Inside City Limits					
lary!	MD Allega	nv (Cumber]	land					1 ☑ Yes 2 ☐ No			
oct oct		7		100 70 0	40		10- 00	***				
Die in	10e. Street and Number			10f. Zip Co			10g. Citizen of \	what Coun	try r			
Ta 123	422 Franklin	Street			502		US					
ifter death with the Ma w items 23s or 28s-1s ther must be nextle	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U,S. 13	 Was Decedant If Yas, specify 	t of Hispanic Origin? (S Cuban, Maxicen, Puerl	specify Yas or No to Ricen, etc.)	- 14. Rac Blac	e - America ck, White, e				
or it	1 Nevar Married 2 Married	1 X Yas 2 □ No If Yes, Give	No 1 Ves 2 No Specific									
by by	3 X Widowed 4 □ Divorced	Year or Dates 940)-1945	100 22	opeany.		Specify: Whit					
	15. Decedent's Ed	ucetion	16a. Dec	edent's Usual O	ccupation fone during most of wo	deina	16b. Kind of B	usiness/ind	lustry			
o o	(Specify only highast grad	College (1-4or 5+)	lifa	. DO NOT use r	etired)	ikiig						
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tel Hygiene. d other than "natur avent, tre Hedical Be Completed	17. Father'a Name (First, Middle, Last)	3			18 Mother's Nar	me (First, Middle	(First, Middle, Meiden Sumeme)					
Mentel Meter of Mentel Meter of Mentel Mente	Alfred Zihlma	an			Estella	M Di	M. Durst					
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if Health and Mentel Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-1 show other traumstic event, the Medical Examiner mant be notified at Other traumstic avent, the Medical Examiner mant be notified at the To Be Completed by Funeral Director	Deborah Lantz		228	E. Han	rison St	. , Cum	berland	IM. F	21502			
nent of the	20a. Method of Disposition 1 De Burial 2 Cremetion 3	memoval from State in	cemetery, ci	remetory or othe	r place)	Date	20C. Location	City or 10	wii, Stata			
and:	4 Donetion 5 □Other (Specify	1 / 3	illcre	st Mem	orial	1/6/99	Cumber	land	, MD			
Department of Health Important: If item 27 any injury or other tr 2008.	21. Signature of Funeral Service/Licens	see A 2	h	22. Name and A	ddress of Facility	oht Eur	orel Her					
Depa Impo any ir	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kight Funeral Home 309–311 Decature Street Cumberland, MD 21502 23a. Part 1. Entar tha disaase, or complications that caused the death. Do not anter tha moda of dying, such as cerdiac or respiratory arrest, interval Betweet Interval Bet											
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nd trans	Sequentially list conditions, Due to (or as a consequence of):											
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,	SUNIL GUPTA, JOHNS			r ROTTD]	ING, CUMBER	LAND, M	ע 21:	502				
State	31. Dete filed (Month, Day Year)	32, Registrar's	Signature	torn.	1							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death ITEM: #5 PER F.H. G768 2-2-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Vaai **Physician** Yola DiGenno 1999 Jan 11 6:43PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner The Memorial Hospital Talbot Easton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (Stete or Foreign Country) New York 8. Date of Birth (Month, Dey, Year) Feb 7, 1925 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2\X Months Hours Min Yrs. 099-18-424 73 Director Usual Residence of Decedent 10d. Inside City Limits 10e State 10b. County 10c. City, Town or Location 1 Wes 2 □ No Director Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Berns 23a or 115 Thompson Street 21643 US Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Y No ff Yes, Givb Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 'natural', or 1 Yes 2 No Specify: White by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Electronics Worker Manufacturing Plant 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) and Mental marked Affinito Adele Campdel John 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ě Health Bern 27 i Madeline B. Meredith 5554 Bonnie Brook Road Cambridge, Maryland 21613 Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other plece)
Unity Washington Cemetery 1/15 20a. Method of Disposition

Washiral 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ne Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thomas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 700 Locust Street Cambridge, Maryland 21613 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner cular kepo Renesis Examine attending physician and for usa as the bunal-transit the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events Box 68760 Physician/Medical resulting In death) Last signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed Diciliato has s certificate ha 1 Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 Yes 2 No 1 Nnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After th completaly filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how Injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

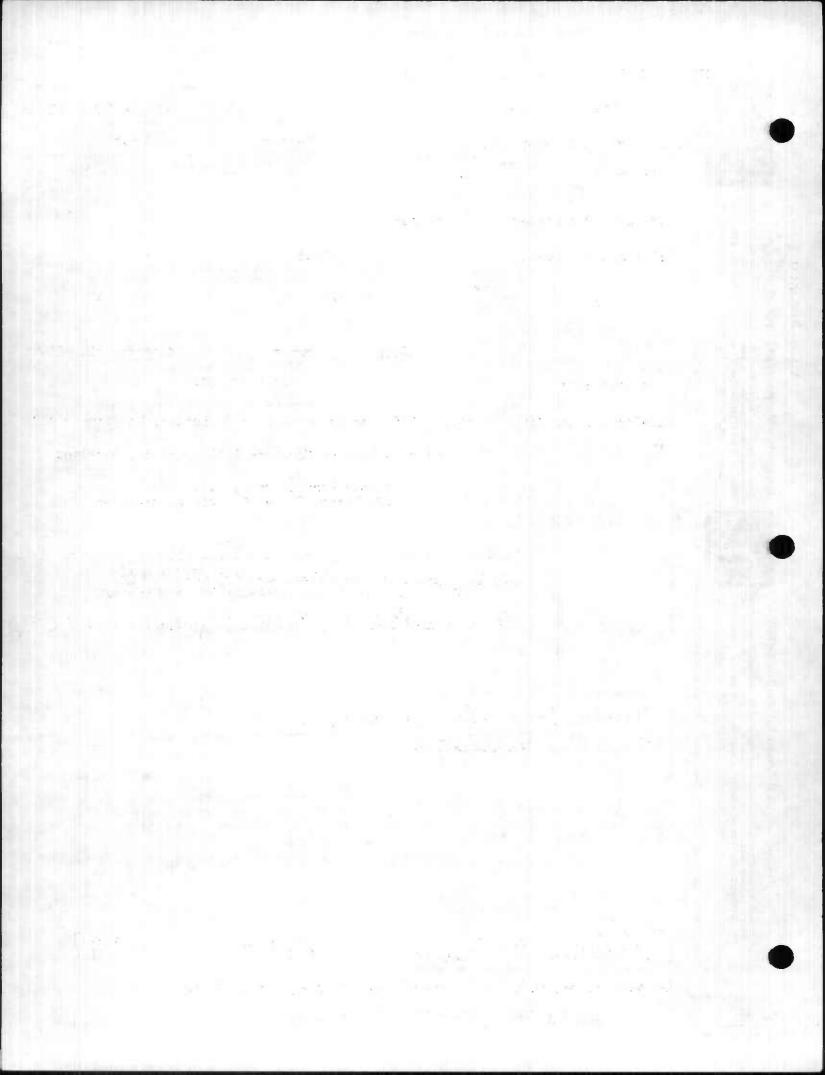
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Name and address apperson who completed cause of death (Item 23a) (Type, Print) Lawrence Bohan, M.D. 606 Dutchman's Lane Easton, Maryland 21601

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Vola Digenno



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month 5, 1999 **Physician** Alton Mainard DeBold Sr. 1:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Undar 24 Hrs. 5. Social Sacurity Number If Under 1 Year 8. Date of Birth Month, Day, Feb. 21, 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 268-01-5360 Director 79 Vre Usual Residence of Decedent with the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Medical Examinet must be notified at Director 1 Tyes 2 XNo Mi. Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 7127 Limestone Lane 21769 U.S.A. death Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Maritai Sfafus 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours attarc Department of Health and Mentai Hygiena. If them 27 is marked other than "natural", or then any injury or other traumatic axest. Black, White, etc. Yes 2 No W. W. If Yes, Giva Year or Dates: 1 Navar Married 3 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) receiver supermarket chain 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be Albert E. DePold Ethel Reid 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Straet end Number or Rural Routa Number, City or Town, State, Zip Code) Vera C. DeBold (Wife) 7127 Limestone Lane, Middletown, Md. 21769 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Memorial Gardens 1/7 Davidsonville, Md. of Fuparal Syvice License 22. Name and Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** strocerebral bleed /Medical immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): burial-trensit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or as a consequence of): physician a the burial P.O. Box 68760, Physician/Medical Dua fo (or as a consequance of): ettending Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the causa of death? signed by t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. py 24a. Was an autopsy performed? 24b. Were autopsy findings available prior fo completion of ceuse of deeth? Completed page 2 hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No cartificata To the Hospital or Attending Physician: "
within 24 hours after death.

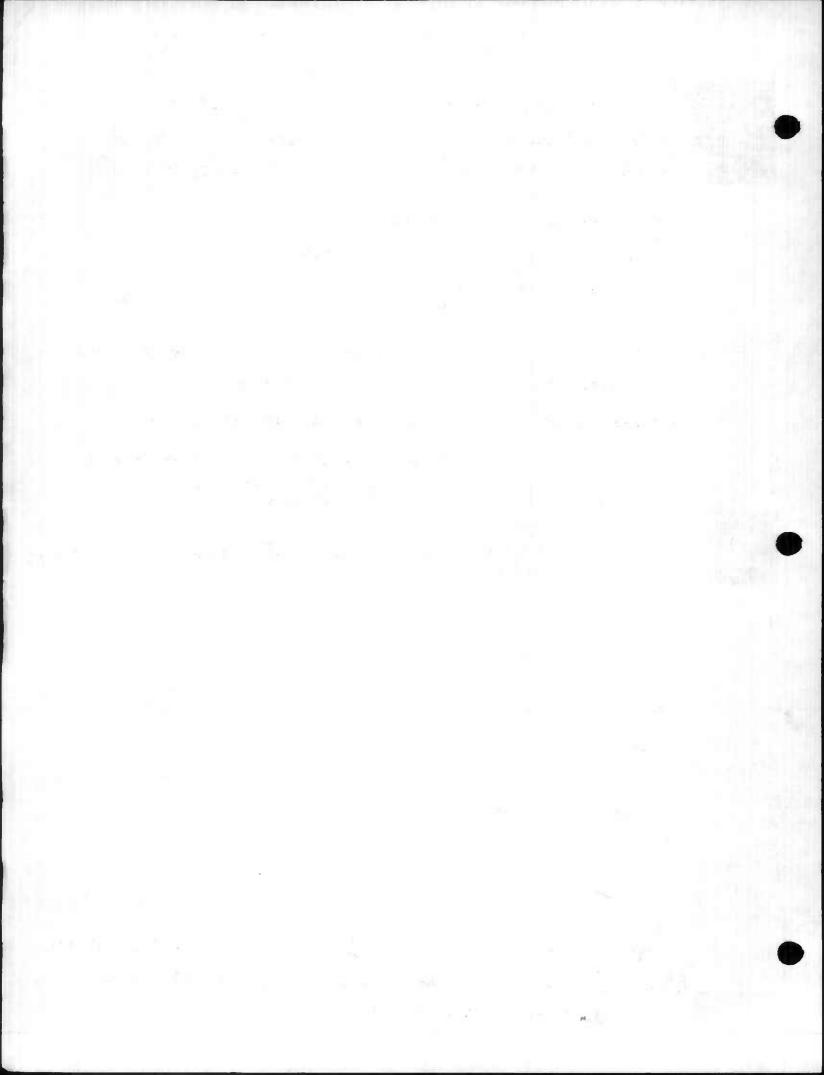
To the Funeral Director: After this cartifica completely filled in by the funeral director; p Be 25. Was case referred to medical 28. Piece of Death (Check only ona) 1□ Yes 2□ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1. Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 4 Homicide Lartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signatura and title of certifier 29d. Date signed (Month, Day, Year) 29c. Licansa number 26516 empleted ceuse of deeth (Item 23a) (Type, Prinf) REDERICK MO 21702 61 KIN 1475 TAWEY

State Registrar 31. Date filed (Month, Day, Year)

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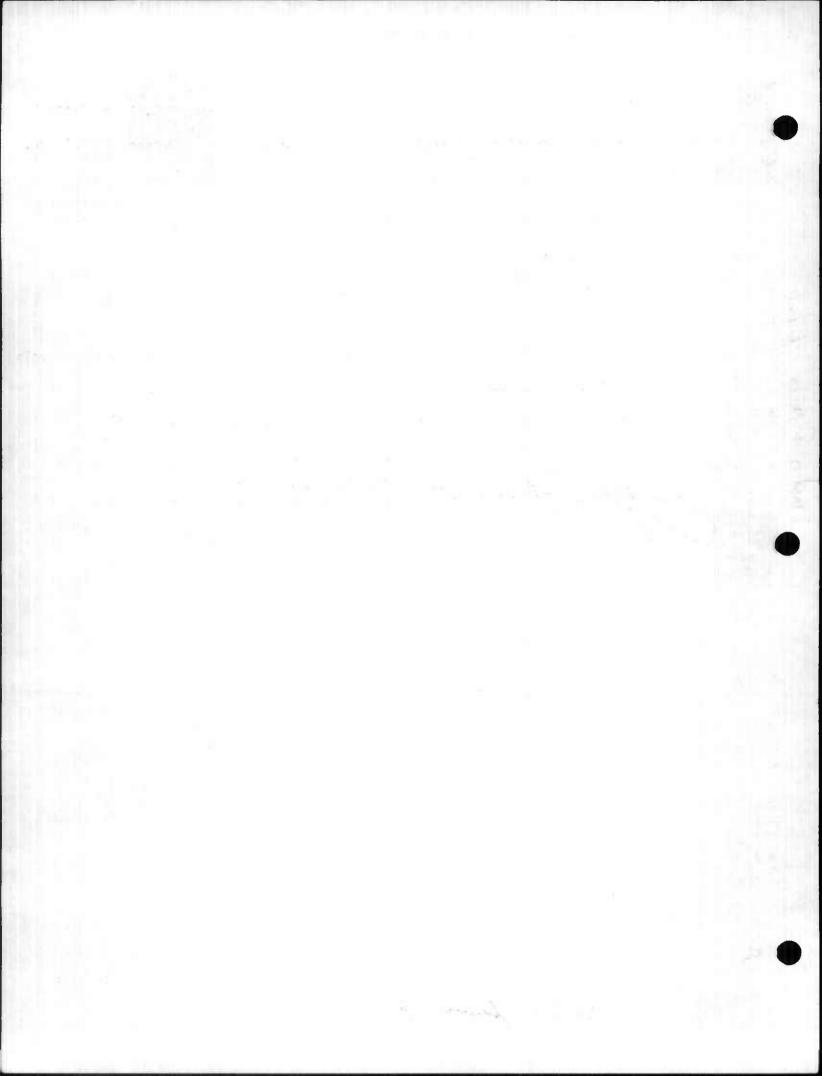
32. Registraris Signatura



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State of Maryland / Department of Health and Mental Hygiene 9 9 1 5 5 6

Physician /Modical		. Decedent's Name (First, Middla, L	44										
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/Medical		IMOGEN	PATRICIA	E.	LLIS					1999	6:17pr		
Examiner	1	e. Facility Name (If not institution, g					4b. City, Town, or	Location of Death	4c. County	of Deeth			
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Funeral Director		219 51 7924	Sex 7. Ag	e (In yrs.	last birthday)	If Undar 1 Yaa Months Days			, Year)	9. Birthpli Count Guya	ace (State or Fo ry) ana		
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or 28a-f show	N		e George's			wie					1X Yes 2[
23a or 2		Oe. Street end Number 12437 Kemmerto	on Lane			10f. Zip Code	715		10g. Citizan of V Guz	Whet Count 7ana	ry?		
72 hours after death with the Maryland natural, or items 23a or 28a-f show sell Evaniner must be notified at steed by Funeral Director	2	Marital Status Nevar Married 2 ☒ Married Widowed 4 □ Divorced	12. Was Decedant Armed Forces? 1 Yes 2 Xi If Yes, Give Yaar or Dates:			as Decedent of Yas, specify Cul	Hispanic Origin? (S ban, Maxican, Puan Specify:	pecify Yes or No- to Rican, etc.)	pecify Yes or No- Black, Whita, etc. 14. Race - American Inc Black, Whita, etc. Specify: Black		tc.		
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Hygiene. thor than *	1	Elementery/Secondary (0-12)	College (1-4or !	5+)	life. Do	O NOT use retir	ed) during most of wo	Naily .					
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d other event, to Be Co	י ב	7. Father's Neme (First, Middle, Las					18. Mothar's Na	me (First, Middla, Maidan Surnema)					
Mental Mental or satic eve	2		seph Moore				1		dora Gilkes				
or other traumatic event,		19a. Informant's Name/Reletionship Clarence Ellis						Rural Route Number, City or Town, Stata, Zip Coda) Bowle, Maryland 20715					
Separation of Health as Important: If item 27 is any injury or other training on the training of training of the training of train	2	20a. Method of Disposition 1 Dete 20b. Pleca of Disposition (Nama of cematery, crametory or other plece) 20b. Pleca of Disposition (Nama of cematery, crametory or other plece) Vreed-En-Hoop Cemetery 1/18/99 20c. Location - City or charging of the cematery, crametory or other plece)											
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Cate has		Seizure	disords					101	on seque	10	Yes 2□ No		
nector, par Be Co	3	 Was case referred to medical examiner? 	Hospital:	Contract	Market In a	In	ther	ath (Check only o	2000	75-74			
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within 24 hours To the Functional Completely III	2	29a. Cartifiar (Check only one) Certifying F	fying Physician: To tha best of my knowledga, death occurred at the tima, date end placa, end due to tha cause(s) and manner es stated. cal Examiner: On tha basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and placa, and due to tha ceus and mannar statad.								ated. tha ceuse(s)		
withir comp		9b. Signature and title of contifier		4			nse number		29d. Date signe		Dey, Year)		
3		Dishouri	- MD				53411		1/10/99	7			
	1 0	0. Neme and address of person who	o completed cause of d	eath (itan	n 23a) (Type, P	rint)		Bonie		2	2.1		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Wentworth A. Ernst 1999 2:15 AM Jan 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Chester Queen Anne's 1412 Queen Anne Drive If Undar 1 Year if Under 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Months Hours 1 M 2□F Yrs 031-03-4353 April 10, 1921 Canada Usual Residence of Decedant 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Queen Anne's Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21619 1412 Queen Anne Drive U.S.A. 12. Was Decedent Ever in U,S. Amped Forces? 1 △ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Engineering 4 Chemical Engineer 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Clara M. Hyson Sidney F. Ernst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Peter W. Ernst Son 1412 Queen Anne Drive, Chester, MD 21619 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriai 2 XCremation 3 ☐ Ramovai from State Jan. 4, 1999 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Ctr Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home PA 0 106 Shamrock Road, Chester, MD 21619 Do not enter the mode of dylng, such as cerdiac or respiratory errest, Approximate tnterval Between Onset and Death Immediate Ceuse (Finei disease or condition resulting in death) (or es e consequence of): edu Sequentially list conditions, it any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveitable prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 □ Yas 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

with the Marylend

death

filed within 72 hours after

Hygiene.

permit. Peges 1 and 2 should be filed Department of Health and Mentel Hygi Important: If item 27 is merked other any injury or other traumatic event, II

altimore, Maryland 21215-0020

Examiner physician end s the burief-transit Physician/Medical 98 USB ò signed by the e þ

the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Hospital

24 hours efter deeth.

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should page 2 hes certificate funeral director, After this

Completed Be 2 Certification:

25. Was case referred to medical 1 Yas 2 No 27. Manner of Deeth 1 Naturai

5 Panding investigation 2 Accident 6 Could not be determined 3 Suicida 4 Homicide

28a. Dete of Injury (Month, Day Year) 28b. Time of

28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and dua to the ceuse(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the ceuse(s) and gnanner stated.

28d. Describe how injury occurred

29b. Signeture and title of certifie

29a. Certifier

(Check only one)

29c. License number

29d. Data signed (Month, Day, Year)

30. Neme end eddress of person

who completed ceuse of death (Item 23a) (Type, Print)

600

Ave Suite 231 Annapolis md 21041

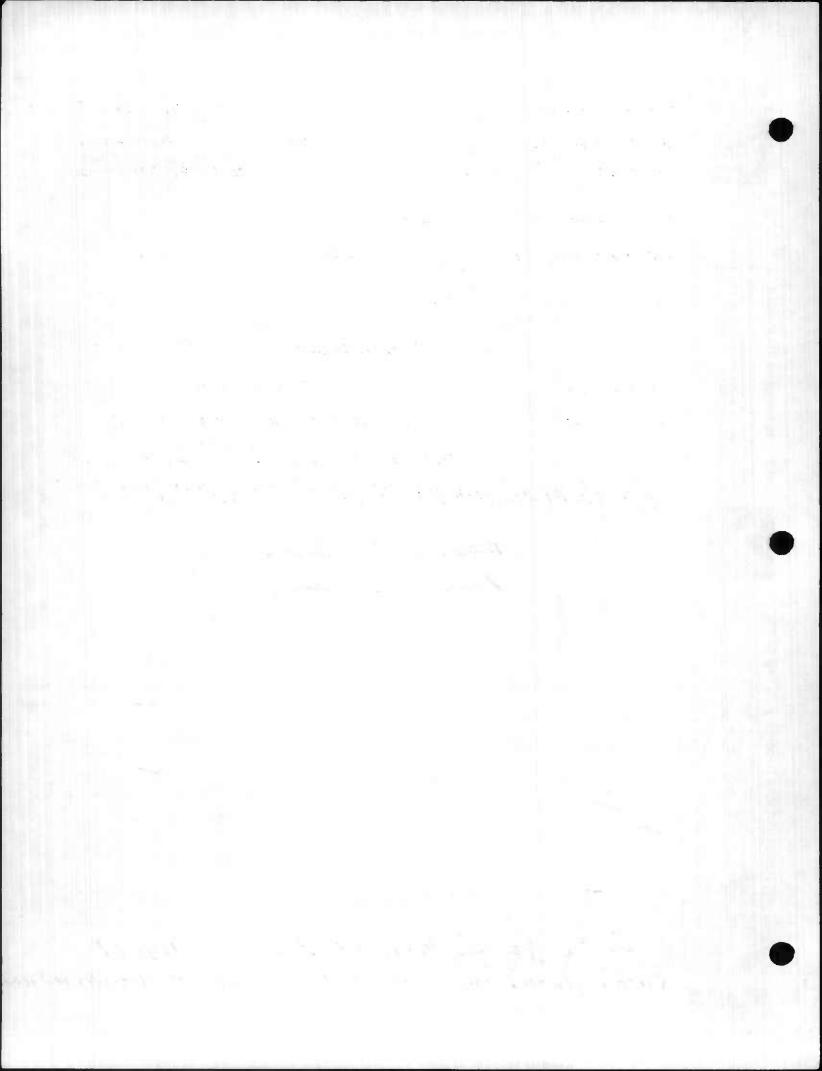
31. Date filed (Month, Day, Ve State

Medical

32. Registrar's Signature

JANO05199

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Date of Death 3. Time of Death Margaret Addline Emerson 1999 2043 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Chestertown Kent & Queen Anne's Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 1□M 2□F 218-16-9281 74 Yrs. Apr. 9, 1924 Maryland Usuai Residance of Dacedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Queen Anne's Church Hill 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 Walnut Street 21623 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 1 ☐ Yes 2√ No If Yes, Give Year or Datas: 1 ☐ Navar Marriad 2 ☑ Marriad 1 ☐ Yes 2☐No Specify: Specify: White 3 Widowad 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Wm. P. Lane Eiementary/Secondary (0-12) College (1-4or 5+) 12 Toll Collector Memorial Bridge 18. Mother's Name (First, Middla, Malden Surname) Mary Della Lister

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10a State

Md.

Director

Funeral

Physician

/Medicai

Examiner

Funeral

Director

28a-f show

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items 23e

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permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If item 27 is marked oths any injury or other treumatic event

traumatic evant, the Medical Exanginer issuit be notified at

the Maryland

Baltimore, Maryland 21215-0020

17. Fathar's Name (First, Middla, Last) William Dill

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19e. Informant's Name/Relationship (Type, Print) William J. Emerson-Husband

502 Walnut St., Church Hill, Md. 21623 20b. Piace of Disposition (Name of cemetery, crematory or other place)

Jan. Date 1999 C. Location - City or Town, State

Queenstown, Md.

St. Peter's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) isease, or complications that ceusad he death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, silure. List only one ceuse on each line

MBurial 2 ☐ Cremation 3 ☐ Removal from State

22. Name and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home 408 S. Liberty St., Centreville, Md. 2161

Immediate Cause (Final disease or condition resulting In death)

CARDIO PULNONARY ARREST

Due to (or as a consequence of):

Myocardial Infaction

Due to (or as a consequence of):

Physician /Medicai Examiner Examiner

physicien and s the burial-trens

2

Physician/Medical

Completed by

Be

Certification: To

Medical

Box 68760,

P.O.

Records,

Division of Vital

Hospital or Attending Physician:

To the Hospital or within 24 hours aft To the Funeral Discompletely filled in

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initieted events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Avenia OFCHMONIE Dipease, Hyper leusen Hypenclulesterolemia, Ostesparosis, O Besity 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

History Right Breast Carcinome Ind MAStectomy 4/90 1 □ Yas S. Was cose referred to medical 28. Place of Death (Check only one)

24a. Was an autopsy performed? 1 Yas 2 No 24b. Wera autopsy findings available prior to completion of ceusa of death?

Approximate Interval Between Onsat and Death

25. Was cese referred to medical examiner?

1 Yes 2 No

1 Yes 2 PNo 27, Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation NONE

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 PAesidence 6 Othar (Specify) 28d. Dascribe how Injury occurred

29a. Certifier

28e. Piace of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifiar

29c. Licansa number 123889

JOHN C. ARRUBACHIS

32. Registra's Signature

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

, 948 WAS Wington Ave, Chestentown Wed 21620

State Registrar Colored Marie Mari

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Lest) 2. Date of Death 3. Time of Death Month illy Owings 1999 2100 PM January 4a. Fecility Neme (If not institution, give street end number 4b. City. Town, or Location of Deeth 4c. County of Death Hospital of Cecil Count Elkyon Union Leci1 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 200F Days 216-20-1226 Sept. 1, 1898 Cecilton, MD Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□ No Maryland Cecil Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 218 East Main Street 21913 United States 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes ※XXNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 11. Marital Status Race - American Indian, Black, White, etc. XXNever Married 2 Married 1 Yes XXNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) 12 4+ School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Robert Edward Ferguson Emma Myerly 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4914 Summitt Bridge Road, Middletown, Delaware 19709

pate 200. Location - City or Town, State Norma Usilton/Niece 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery/January 16, 1999 Cecilton, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Tellows, Helfenbein & Newnam Funeral Home, P.A. 26 E. Main Street, Cecilton, Maryland 21913
Approximate the mode of dying, such as cardiac or respiratory errest,

Approximate Immediate Ceuse (Final 15 days disease or condition resulting in deeth) neumenia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in daeth) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? atrial fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evellable prior to 24e. Wes an autopsy performed? completion of cause

Physician /Medicai Examiner

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permit. Pege Department of Important: If eny injury or once.

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show items 23e or 28a-f shov

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natural',

Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. nnt: If Item 27 Is marked other than 1ry or other traumatic event, Ite Ma

Director

Funeral

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Completed

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death

filed within 72 hours efter

21215-0020

Saltimore, Maryland

ete has been signed by page 2 should be detect spital or Attending Physhours efter death.
neral Director: After this y filled in by the funeral di

this certificate has

The law requires that the death certificate be executed

Box 68760

P.O. 1

Division of Vital Records,

Examiner Physician/Medical Completed Be Certification: To

Medical

30

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. congestive heart failure

1 ☐ Yes 213 No 1 ☐ Yes 2 ☐No 25. Was cese raferred to medicel 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpetient 3 DOA 27. Manger of Death Date of Injury / (Month, Day Year) 28b. Time of 28d. Describe how injury occur 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and City or Town, State) Number or Rurel Route Number. 4 Homicida 29a. Cartifier

Certifying Physician: To the best of my knowledge, daeth occurred at the tima, data and place, end due to the causa(s) and mannar as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the causa(s) end manner stated. 29b. Signature end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number

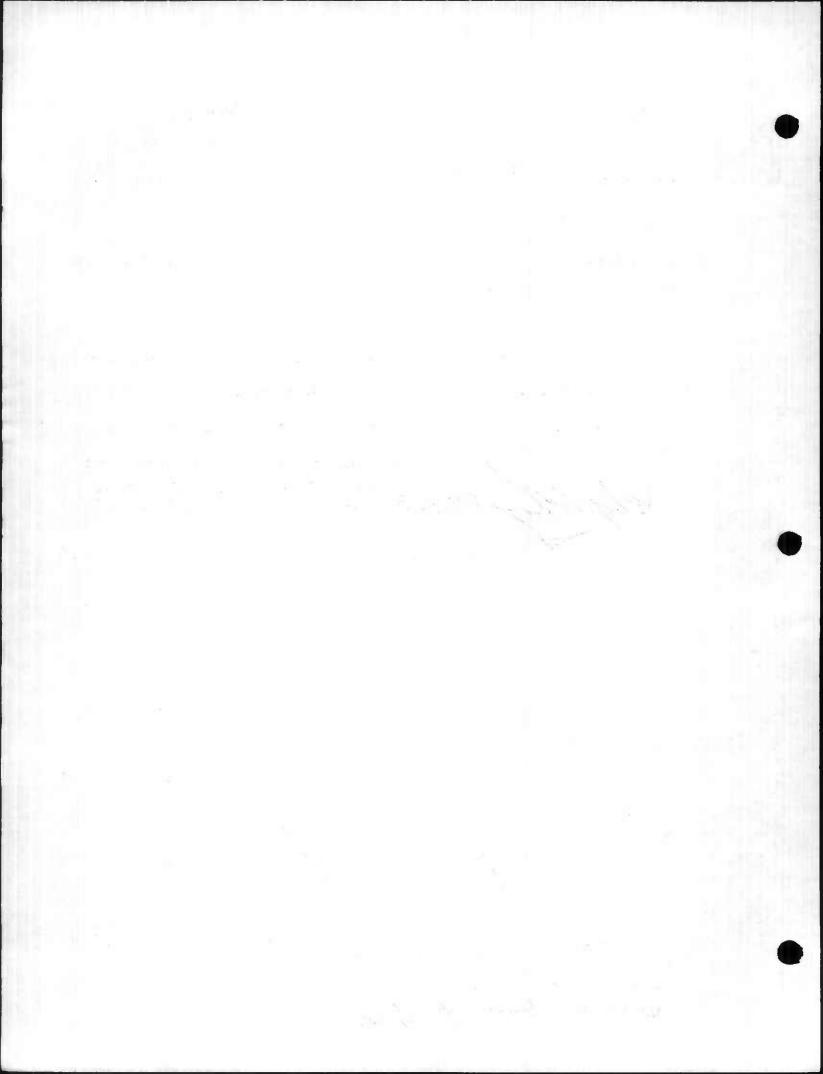
1/13/99

30. Nema and address of person who complated causa of death (Item 23a) (Type, Print)

Wallace Obenshain, MD, Route 213, Cecilton, Maryland 21913
31. Deta filed (Month, Day, Year)
32. Registrar's Signeture 31. Deta filed (Month, Day, Year) JAN 1 4 1999

Registrar

To the Hospital o within 24 hours of To the Funeral D completely filled i



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death	-	9	0	1
Certificate of Death Reg. No.	, -		~	
2 Date of Death				3

Physician	
/Medical	
Examiner	

Time of Death

3:20 PM

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

20902

20852

Approximate interval Between Onset and Deeth

1 Yes 2 No

Funeral

Director the Marylend

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examinar must be notified at

Physician

Baltimore, Maryland 21215-0020

physician and s the buriel-trens certificate be 80 esn page 2

P.O. Box 68760. Division of Vital Records. or Attending Physician: After this funeral efter deeth. Director: Aft • Funeral Hospital completely To the F within 2

Be

To

Certification:

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1 Decedent's Name (First Middle Last) Month MILDRED SCHULMAN FEIN 01.03.1999 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) CARE MATRIX OF SILVER SPRING SILVER SPRING MONTGOMERY if Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 M 25 F 94 Yrs. 488.36.3934 10.13.1904 RUSSIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours effer death with it. Department of Health and Menial Hygiene. Important: If itam 27 is marked other than "natural", or frems 23a or 2 any injury or other traumatic event, the Medical Example must be not. 1804 BILLMAN LANE 20902 USA Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify Specify: þ WHITE 3 ₩idowed 4 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 RETAIL SALES CLERK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be MOSES GALITZKY MERIL MILSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J.M. SCHULMAN/SON 1804 BILLMAN LANE, SILVER SPRING, MARYLAND 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donation 5 Other (Special) SHEFFIELD CEMETERY 1.6.99 KANSAS CITY, MO 21. Signature of Funeral Service 22. Name and Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part. Easer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequenca of): Physician/Medical Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No Advanced Dementia þ 24a. Was an autopsy performed? Completed

Renal insufficience

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending

6 Could not be

Hospital: 28a. Date of Injury (Month, Day Year) Investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No

28. Place of Death (Check only one)

28d. Describe how injury occurred

1 Yes 2 No

29a. Certifier (Check only one)

1. Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signatore and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

01.04.1999

Name and address of person

31. Date filed (Month, Day, Year) **JAN 1 1**

32. Registrar's Signature

Ave#400 SilverSpring MD 20010

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** January 12, 1999 8:00 AM Ann Margaret Forrest /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Care - Laurel Prince Georges Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stete or Foreign Country) **Funeral** Min. Deys 1 M 2 X F Months Hours 218-09-1693 83 Director Dec. 26, 1915 Maryland Usuel Residence of Decedent the Maryland 10a, Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Silver Spring Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 15300 Pine Orchard Drive 20906 USA Homa 23a Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Detas: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, 11. Meritei Status pemit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiens. Introduction: if item 27 is marked other than "natural, or item eny injury or other treumatic event, the Medical Control once. Bleck, White, etc 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify. þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Thomas Kane Catherine Clisham 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) (son) 7511 Mandan Road, Apt. 303, Greenbelt, MD John Forrest, III 20770 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Burlai 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 1/15/99 Timonium, MD 22. Neme end Addrass of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 21. Signature of Funeral Service Licensee Home, Inc. 20901 Silver SPring, MD Clon xyonal 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finel diseasa or condition rasulting in deeth) /Medical minutes Examiner Due to (or es e consequenca of) Examiner attending physician and for use as the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or es a consequença of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings availabla prior to completion of cause of death? 24e. Wes an autopsy performed? Completed has 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) 35 No Hospitel: 1 ☐ Inpatiant Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Naturei 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred To the Hospital or Attending PI
within 24 hours after death.
To the Funeral Director: After th
completely filled in by the funera 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 6 ☐ Could not be 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated. (Check only one) 29b. Signature end title of certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23e) (Type Print)

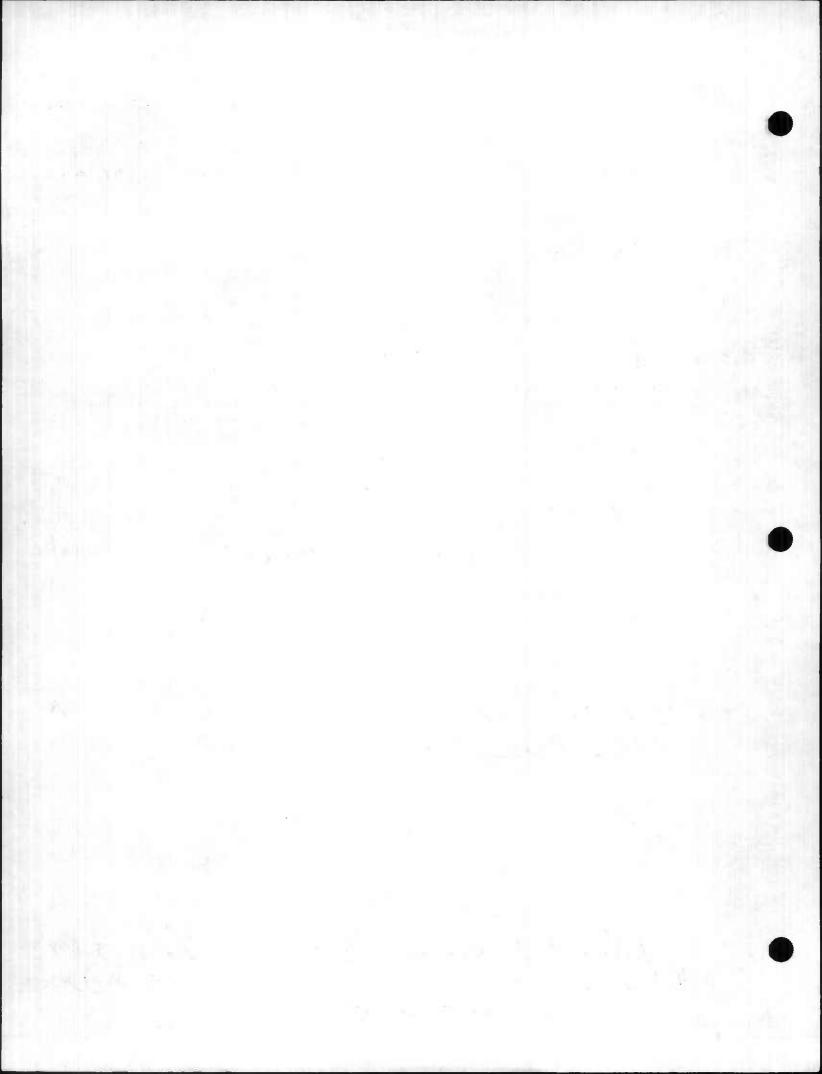
State Registrar 31. Dete filed (Month

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32. Registrer's Signeture

1999

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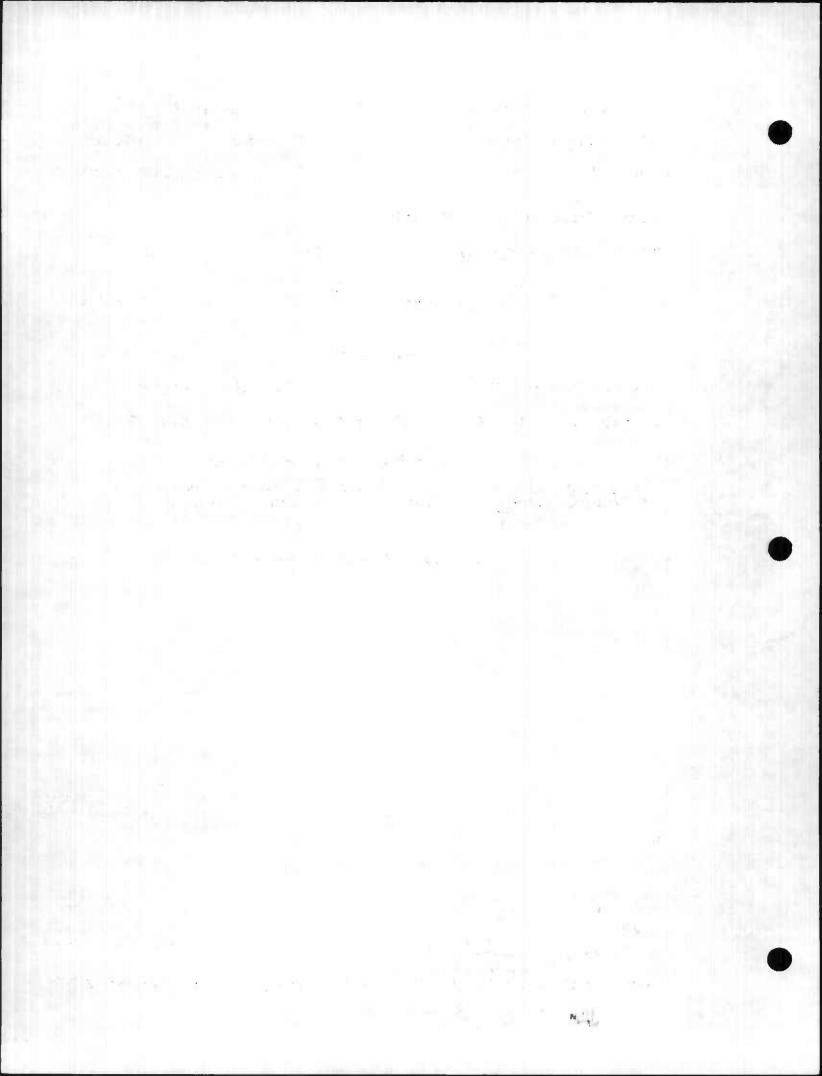


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State of Maryland / Department of Health and Mental Hygiene 9 9 1562

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Funeral Director		100-10-0074	Sex 7. Age	e (In yrs. Ia. 80		If Under 1 Months I	Days Hour	der 24 Hrs. S Min.	8. Dete of Birth (Month, Dev Oct. 29	, 1918	9. Birtho Cour Mar	plece (State or Foreign http:// yland
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Baltimore, Mar permit. Pages 1 and 2 sh Department of Health end Important: If itsm 27 is m any injury or other traum once.		20e. Method of Disposition 1		cer	ce of Dispositi metery, cremai nt Olivet	c Cemet	erpiace) tery, Ja		9, 1999		ick,	Maryland
Department Popular Important Popular P		21. Signature of Funeral Service Lice	Hal	MOO 2	²² K	eeney	Address of Fe Bas Et Chur	ford	P.A. Fur	neral H	ome arvla	and 21701
Physician /Medicai Examiner	ler	Immediate Ceuse (Final disease or condition resulting in death)			erotic		liovasc	ular	Disease		1	Years
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To the within To the compl	Me	29b. Signature and title of certifier —	tue	-	1		License numb 35164	er .		^{9d. Dete signe} January		
		30. Name and address of person who Andrew Zarick,					k Stre	et, F	rederic	, Marv	Land	21703
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State of Maryland / Department of Health and Mental Hygiene 9 0 1563

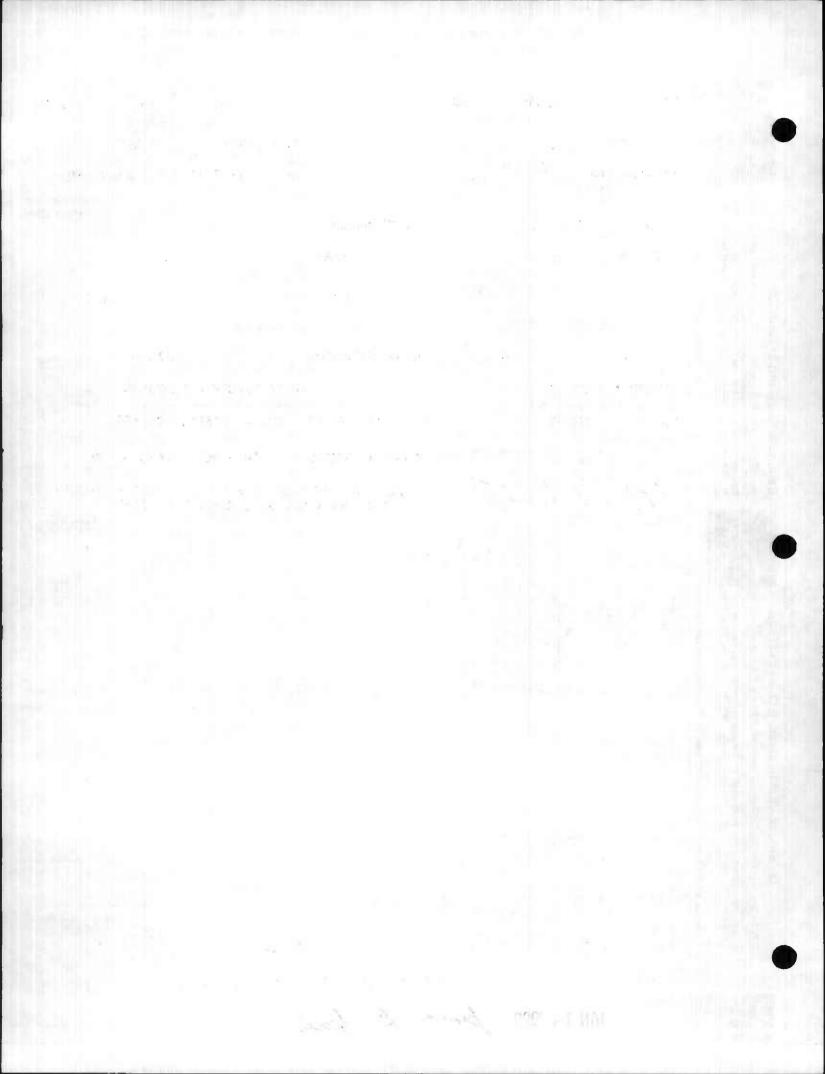
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Lammer	1113 POLK STREET				ST. MIC	HAFLS					
Funeral Director	5. Social Security Number 6. Security Number 214-46-4506	7. Age ☐XM 2□ F 58	(In yrs. lest birthday, Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs.	8. Date of Birth (Month, Dey SEPT . 10	Year)	Birthplace (State or Foreig Country) MARYLAND			
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or 20	10e. Street and Number			10f. Zip Code		1	log. Citizen of V	Vhat Country?			
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Physician /Medical Examiner	23e. Pert1. Enter the disease, or compshock, or heart feilure. List only of the disease or condition resulting in death)	a. Lu.	he deeth. Do not er	iter the mode of dy	ing, such es cardiac	or respiretory err	rest,	Approximate Intervel Between Onset end Deeth			
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ificate be axecuted g physician end as the bunal-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	b	ue to (or es a conse	quence of):							
5 O 0 =	Ceuse (Disease or injury the Initiated events Due to (or es e consequence of): resulting in death) Last Due to (or es e consequence of):										
nat the death cer d by the ettendin letached for use Physician/N	ALC: N. C.	d									
requires that the death certific been signed by the ettending p should be detached for use as:	Pert II. Other elgnificant conditions co	ntributing to death but	ven in Pert I.	23b. Did to	/	ntribute to the cause of death					
2 10 01 0						24a. Was a perfor		24b. Were eutopsy findings available prior to completion of cause of death?			
The law te has age 2						1 U Y	es 2 No	1 ☐ Yes 2 ☐ No			
	25. Wes case referred to medical				26. Plece of Deat						
Physician: r this cartific ral director,	examiner? 1 Yes 2 No	Hospital: 1 Inpatien	t 2 ER/Outpetie	nt 3 DOA Ot		ome 5 Resid		er (Specify)			
i or Attending Physical astar death. Director: After this d in by the funeral direction: Terrification: Terrif	27. Menner of Death 1 Interpreted 5 Pending investigation		Year) 28b. Time (Injury	Wo		28d. Describe h					
tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pleca of Injur building, etc.		28f. Location (S City or Tow		er or Rurel Route Number,					
he Hospi in 24 hou he Funer pletely fil edical		relcian: To the best of iner: On the basis of e end menner state	examination and/or to					nner as stated. and due to the cause(s)			
To the Within Common	29b. Signeture end title of certifier	mo		29c. Licen	. License number D44749			d (Month, Day, Year) 14, 1999			
State	30. Name and eddress of person who con PETER L. WHITE 31. Date filed (Month, Day, Year)		, 508 IDL		ENUE, EAST	TON, MD	21601				

Genera G. Sparks

DHMH 16 Rev 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Yee William Thomas Gowran 10:10am January 8, 1999 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meridian Nursing Center Randallstown Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) 1₽M 2□ F Days 218-10-3696 Yrs. 88 Dec 5, 1910 Maryland Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. inside City Limits Baltimore Randallstown 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10746 Liberty Road 21133 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marifal Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo if Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 8 Laborer Balt. City Roads Dept 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) William Gowran Mary (Unknown) 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) Mrs. Andrea Drury (Daughter) 106 Brown Street Centreville, MD 21617 20b. Piece of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremation 3 Removal from State 4 Donation 5 Ofher (Specify) Good Shepherd Cemetery 1/11/99 Ellicott City, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) 21. Signefure of Juneral Servica Licansee Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresf shock, or heart feilure. List only one cause on each line. interval Between Onset end Death fmmediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No bheral hascular disease 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an eutopsy performed?

Physician /Medical Examiner

physician and the bunal-trensit

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of or Attending Part of the Court of the Cou

To the Hospital or within 24 hours aff To the Funerel Di

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P.O. Box 68760,

Records,

Division of Vital

Examiner

Physician/Medical

Completed

Be

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Certification:

edical

permit. Peges 1 and 2 should be filed within 7; Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medis once.

Physician

/Medical

Examiner

10a State

Director

PV

MD

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

the Maryland

with

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf

Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 26. Place of Death (Check only one)

completion of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

Date of injury (Month, Dev Year) 5 Pending Investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

1 Neturai

3 Suicide

2 Accident

4 - Homicide

Ecertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) and menner es steted. 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) and menner stated.

29b. Signature end title of certifier awayo

6 Could not be determined

29c. License number

29d. Dafe signed (Month, Dey, Year) 1/9/1999

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

TAHOORA KAWAJA 1777

Town Rd #108 Baltimore Keiste

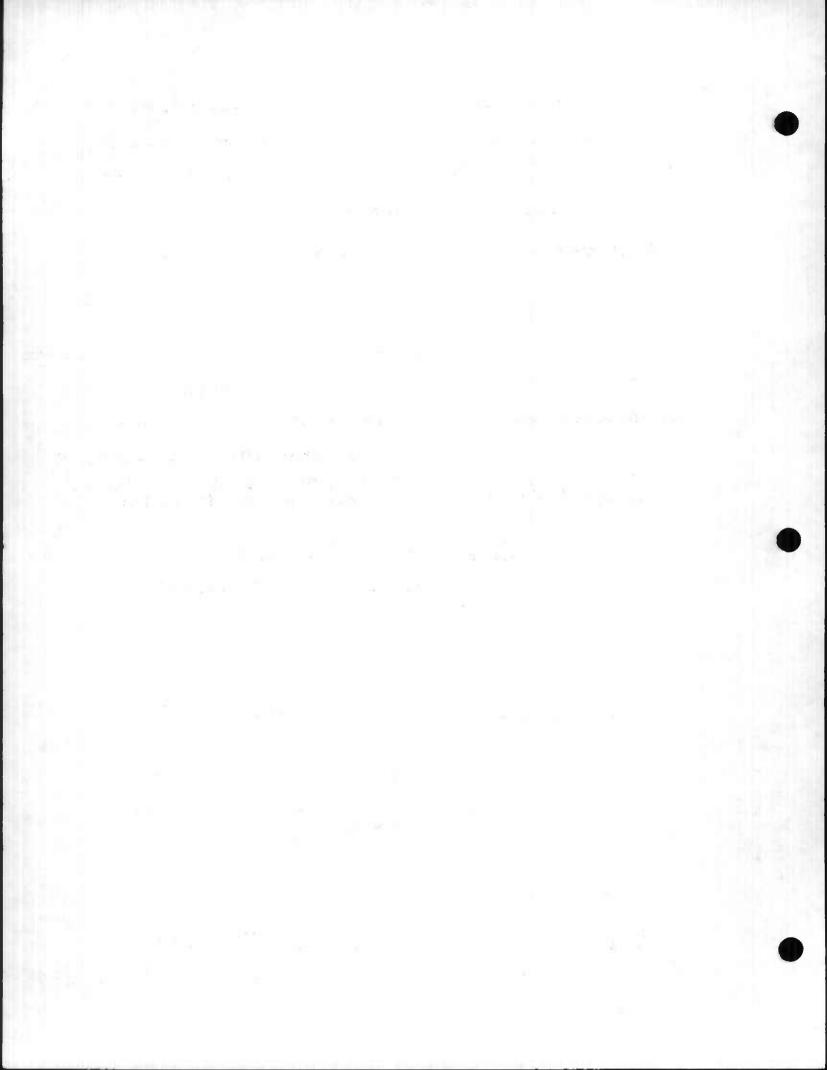
State Registrar

JAN 1 1 1999

31. Date filed (Month, Day, Year)

32 Registrar's Signeture

28e. Place of Injury - Af home, farm, sfreet, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #1,1/12/99,BMW,Montg.Co per physician Certificate of Death 2. Defe of Daafh 1. Decedent'a Name (First, Middle, Last) Month **Physician** Tatiana January Guevorguian 8, 1999 7:20 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) 9. Birthplaca (Society) Dec. 26, 1915 Russia If Under 1 Year If Undar 24 Hrs. Hours Min. Birthplaca (State or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🗙 F 83 070-36-1558 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show Md Frederick Nas 2 No Frederick Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? rms 23a or i 1922 Timber Grove Road 21702 Funerai USA 12. Was Dacedanf Evar in U,S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give 14. Race - Amarlcan Indian, Black, Whita, etc. r than "natural", or items the Mapical Exercises my Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ Never Married 2 ☐ Married Battimore, Maryland 21215-0020 1 Yes 2 No Spacify: Specify.White ò 3 Widowad 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Clerk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Eurpean American 12 ment of Health and Should be filed w ment of Health and Mental Hygie tent: I frem 27 is marked other to lury or other traumatic event, to Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Gregory Kourilo Olga Skripnichenko

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Nick Kourilo/ Nephew Midsummer Drive, Frederick, Md 21702 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1/11/99 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Department of Important: If Russian Orthodox Cem Spring Valley, N.Y. 21. Signature of Dimeral Service Lipensee 22. Nama and Address of Facility Philip D.Rinaldi Funeral Service 11818 New Hampshire Ave. Silver Spg Md.

25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

Approximate Physician /Medical Immediate Cause (Final HEMMON WAGE disease or condition resulting in death) Examiner HYPERTENSIUM Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 2 Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 1 Yes 2 No signed by 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yes Jan No 1 Yes certificate Division of Vital Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifice 25. Wes cese referred to medicat Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 | Yes 2 | No 2 Accident 6 Could not ba determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours

To the Hosp within 24 hor To the Fune completely fi

State Registrar

Medicai

29a. Certifier

(Check only one)

29b. Signature and fitte of certifier

31. Date filed (Month, Day, Year) JAN 12 1999

WAMI NATHAN

Va Nath

2Q. Neme end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

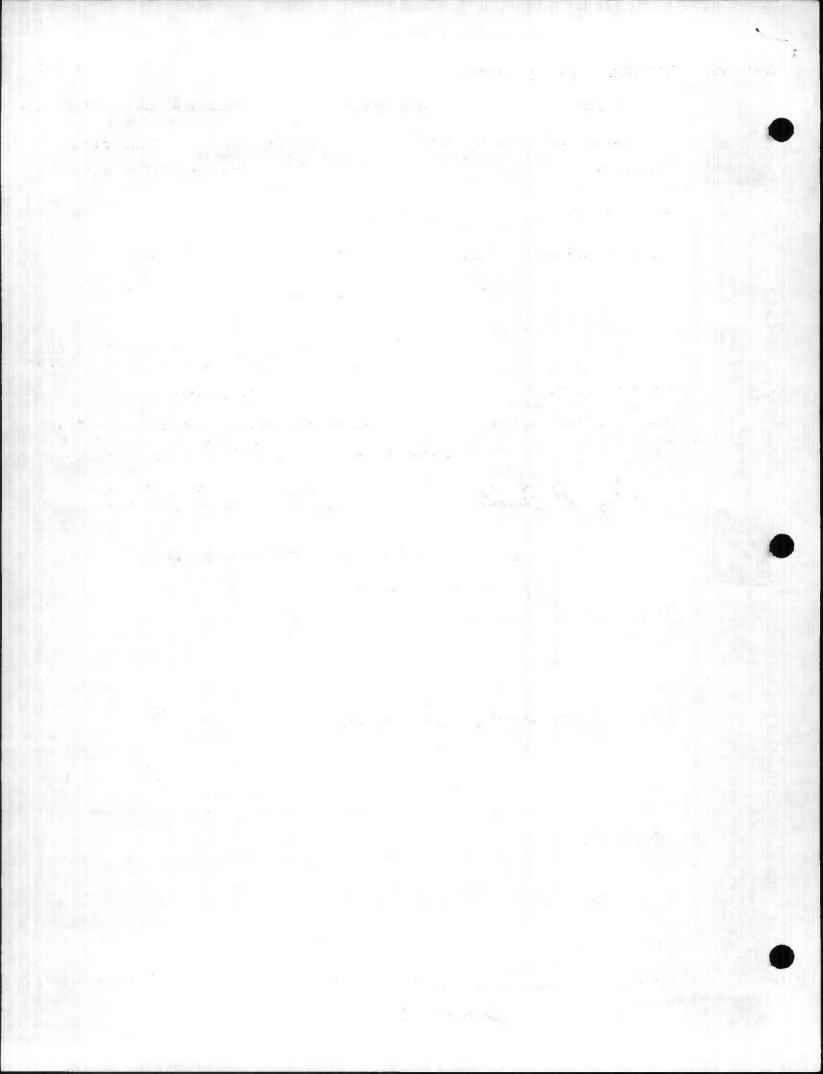
198 Thomas Futures N Dr. 207 Flog, nd-2170) MO 32. Registrar's Signature

Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Exeminer: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #19a, 1/11/99, BMW, Montg. Co Certificate of Death 2. Data of Daath 1. Decedant's Nama (First, Middla, Last) 3. Time of Death **Physician** LILLIAN G. GREENBERG 01.06.1999 6:25 PM /Medical 4a Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY | If Undar 1 Year | If Undar 24 Hrs. | 8. Data of Birth (Months, Days Hours Min. | 03.18.1914 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1 M 2 F 089.05.6749 84 Yrs. NEW YORK Director Usual Residence of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No MARYLAND MONTGOMERY Directo POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9617 HALL ROAD 20854 Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Married natural', or 1□ Yas 2 No Spacify: Specify: WHITE ð 3 Widowed 4 □ Divorced be filed within 72 houtel Hygiene. d other than "natura 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) SECRETARY EDUCATION 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Mentel SAMUEL GOTTFRIED IDA CHERNER 19a, Informant's Name/Ralationship (Type, Print) RONNIE SPETIN DAUGHTER 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 sh Department of Health and Important: If fem 27 is m any Injury or other traum once. 9617 HALL ROAD, POTOMAC, MARYLAND 20854 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Spacify) NEW MONTEFIORE CEMETERY 1.10.99 Pinelawn, L.I. 21. Signatura of Funaral Sarvica Licenses 22. Nama end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND AND 20852 Approximata Intervel Batwaen Onset end Deeth 23a. Part1. Enter the disease of complications and caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immadiata Causa (Final disease or condition resulting in daath) Myocardial Infarction Dua to (or as a consequence of): minutes Examiner Cardiovascular Disease Physician/Medical Examiner physician and s the burief-trans Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last Due to (or es e consequence of): 98 Part It. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Mellitus Diabetes þ 24b. Wara autopsy findings evailable prior to 24a. Was an autopsy performad? Completed complation of cause of daeth? 25. Was cesa rafarrad to medical examinar? Be 26. Placa of Daath (Check only ona) 1 Yas 2 No Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 3 DOA 1 ☐ Inpatiant 2 ☐ ER/Outpatiant this 27. Mannar of Daath 1 Natural 2 Accident 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Certification: 5 Panding Invastigation 1 Yas 2 No Director: / 6 Could not ba datamined 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicida

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Greenberg January 6, 1999

Lillian

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To the Within 2 0 00 0

> State Registrar

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31. Data filed (Month, Day, Yaar) 1999

29a. Cartifia

(Check only one)

Katharine R. Lillie, M.D. 32. Ragistrar's Signatura

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) 11140 Rockville Pike #348

Rockville, MD 20852

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29c. Licansa numbar

53244

29d. Data signad (Month, Day, Year)

January 6, 1999

DHMH 16 Rev 6/95

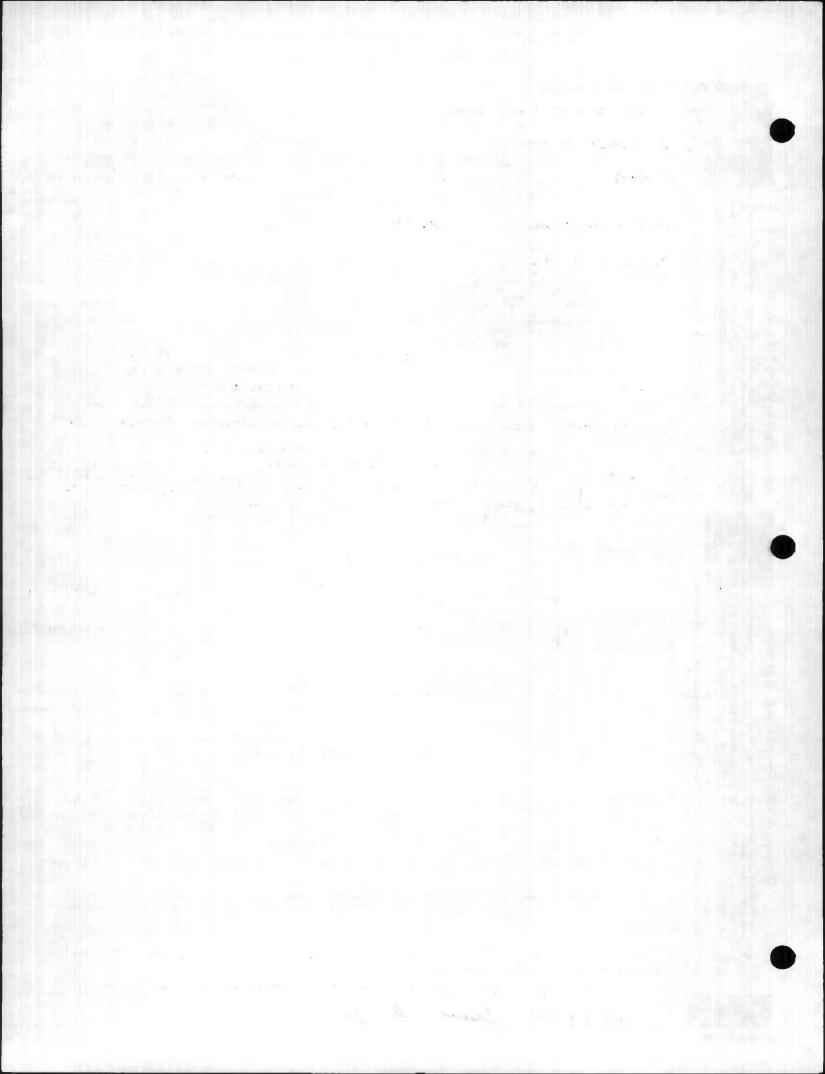
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State of Maryland / Department of Health and Mental Hygiene 9 0 1 5 6

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21215-0020 od within 72 hours ef giene. or than "natural", or the wedge Earth	Eo	Elementary/Secondary (0-12)	4	ge (1-4or 5+)	Home	make	er			Own Ho	me			
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Maith alth		James A. Green	ne/Husbar	nd	301	Brad	lley	Avenue, 1	Rockvill	e, Maryl	land	20851		
of He		20e. Method of Disposition		200	. Plece of Disponentery, cre	osition (f	Veme of	Jan. 1	Date	20c. Location -	City or To	wn, Stata		
Pege rent of		1 X Buriel 2 ☐ Cramation 4 ☐ Donetion 5 ☐ Other (rom State	late of	Heav	ren C	emetery	1, 1999	Silver	Spri	ng MT)	
Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mental Hygiene. Importment: If filem 27 is marked other than "natural", or items 23s or 28s-1 show any Injury or other traumatic event, the Magical Exeminer must be not less.	9	21. Signetula of Fahurel Service	Licencee		2	2. Neme	end Addr	ess of Fecility R	obert A.	Pumphre	y Fu	neral	Home/	
m aaes	DUCE.	Rockville, Inc. 300 West Montgomery Avenue												
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Di To the Hospital or within 24 hours efte To the Funeral Dir completely filled in		29a. Certifier 1 Certify (Check only 2 Medica	ng Phyeiclen: To	the best of my k	nowledge, deet	h occurre	ed et the t	ime, dete end plec opinion, death occ	e, end due to the	ceuse(s) end me	enner es st	eted.	-1	
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4		Pryour	9 Ki	hee	and		D0	021033		January	11.	1999		
	14	30. Name end address of perso	who completed	cause of deeth (I	tem 23e) (Type,	Print)								
		Byoung K. Lee,		3000 Geo	rgia Av	enue	, Si	lver Spr	ing, Mar	yland 2	20906			
	State	31. Dete filed (Month, Day, Yea	7) 3	2. Registrer's Sig			1	1,	2.10					

DHMH 16 Rev 6/95



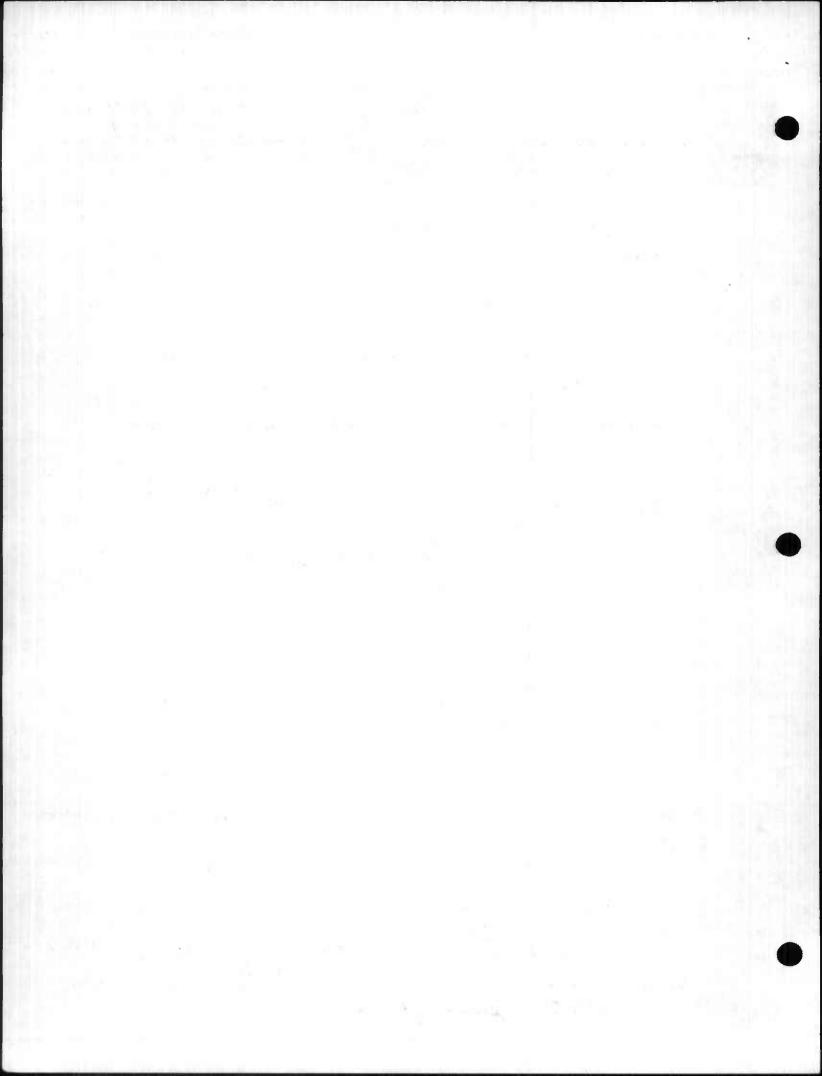
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend #26,1/13/99,BMW,Montg.Co.perphysician Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month William Jan 26011 20 Wan 1999 1015 /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Deaff Examiner Silver Sprin Hanbers. mont | Sr/Vel | Spire | House 14 Hrs. | S. Date of Birth | Months | Days | Hours | Min. | Oct. 21, ome & 9. BiltHolace (State or Foreign Country) 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 11XM 2□ F 485-01-7846 Yrs. 79 Director 1919 Iowa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Items 23s or 28s-f show insermant be notified at 10d. Inside City Limits 1X Yes 2 No Director Douglas Omaha 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5806 Oak Hills Drive 68137 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedenl of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 11. Marital Status the Medical Examiner filed within 72 hours efter 1 ⊠ Yas 2 □ No If Yes, Give Yaar or Dates: WWII 1 Never Marriad 2 Married 21215-0020 ò 1 ☐ Yes 2 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Engineer other 1 traumetic event. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) . Pages 1 and 2 should be fill ment of Heelth end Mentel Hant: If item 27 is marked oth jury or other traumatic even William Lee Gowan Beuleh Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) Rebecca Gowan 5806 Oak Hills Drive, Omaha, NE (wife) 68137 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Pinelawn Memorial 1/16/99 Rapid City, SD 22. Nama and Address of Facility Francis J. Collins Funeral 21. Signature of Funeral Sarvice Licensae Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 23a. Furt1. Enter the disease, or complications that caused the death. Do not anter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediete Ceuse (Final disaase or condition resulting in death) Examiner Due to (or as a consequenca of) Attending Physician: The lew requires that the death certificate be executed buriel-transit pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in daath) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the Dua to (or as a consequence of) been signed by the e should be deteched t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1□ Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performed? Completed hes 1 Yes 20 No this certificate 1 ☐ Yes 2 ☐ No director. 25. Wes case referred to medical Be 28. Place of Deeth (Check only one) exeminer? Other: 4 Nursing Home The Souther (Specify) residence Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 1 Naturel 5 Pending 1 Yes 2 No deeth. spital or Attendi nours after deeth. neral Director: A 2 Accident investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours ef To the Funeral Di completely filled in Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signa and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) 20+ 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) BRECKER, no DINE

32. Redistrer's Signature

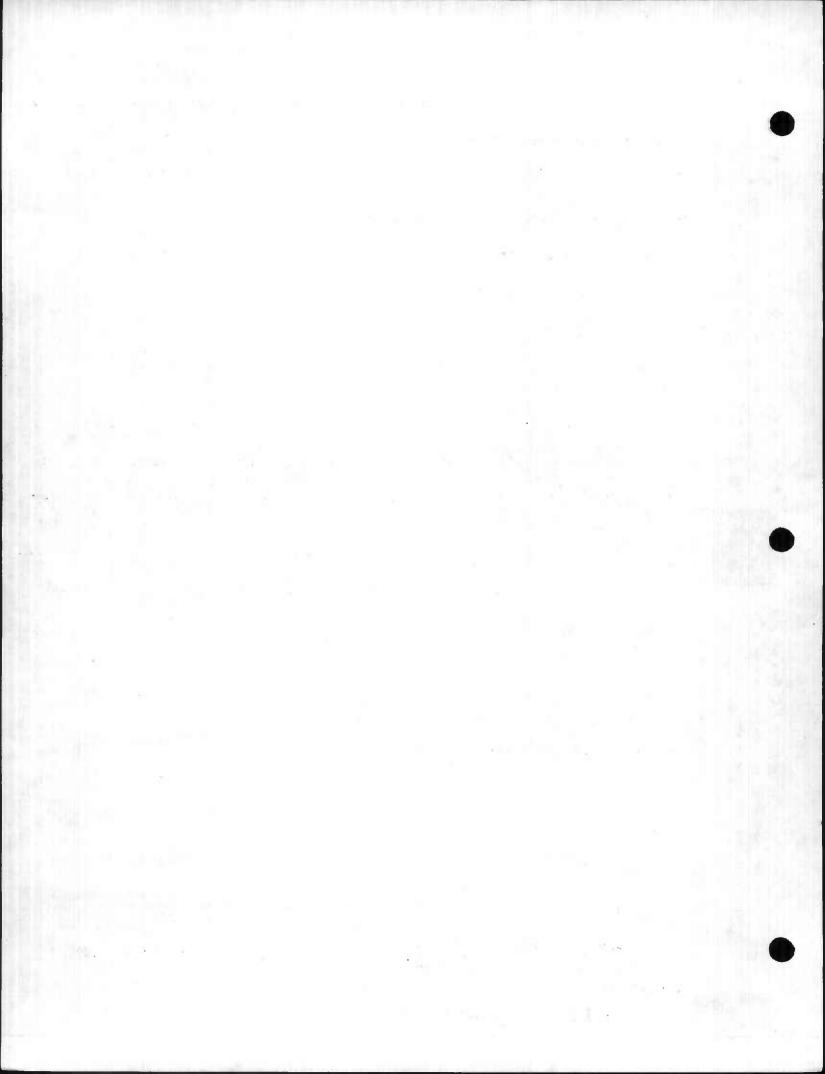
State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.	569	
Dhuaisian		leta of Death Aonth Dey Year	3. Tima of Death	
Physician /Medical	WILLIAM N. GAUT JA	NUARY 12, 1999	5:30 AM	
Examiner	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location			
	211 RUSSELL AVENUE, APT. #500 GAITHERSBUR 5 Social Security Number 6 Sex 7 Age (In vrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8 D			
Funeral Director	Months Days Hours Min (A	ate of Birth Wonth, Day, Year) 1y 13, 1900 9. Birthplac Country Michi		
Pag Bu	10a. Steta 10b. County 10c. City, Town or Location	10d.	Inside City Limits	
Man Man	Maryland Montgomery Gaithersburg		1 Yes 2 No	
or 28ef s be notified	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country	?	
P will	211 Russell Avenue, Apt. #500 20877	United Sta	tes	
0020 hours after death with the Maryla uret, or thems 23s or 28e4 sho at Examiner must be notified at cd by Furneral Director	11. Maritat Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Merried 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican 1 Yes 2 No Specify:	Yes or No- n, etc.) 14. Race - American Bleck, White, etc Specify: Whi		
72 ho	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Businass/Indus	itry	
21215-0020 od within 72 hours at yolene 72 hours at t, the Medical Exam Completed by 1	(Specify only highest graide completed) Elementery/Secondary (0-12) 12 (Give kind of work done during most of working life. DO NOT use retired) Engineer	Musical		
		st, Middle, Maiden Sumeme)	-	
Maryland d 2 should be lite in and Mental Hy 7 is marked oth traumatic event	Leverett Gaut Nora	Hutchins		
Bary 2 sho and N	19e, Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Rou	ste Number, City or Town, State, Zip Co	ode)	
N , N	Harold W. Gaut, Son 6917 Muncaster Mill Road,	Derwood, MD 208	55	
Pages 1 ent of H mt. if Nen ry or oth		12,		
altir antm ortan	21 Storaghay of Europe Service Despess	,	irginia	
W 89 1 1 8	4 2	Vol Funeral Home	00077	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responds, or heart failure. List only one ceuse on each line.		oproximate	
Physician //	Immediate Cause /Finel	0	tarval Batween	
Examiner	disease or condition resulting in deeth) Due to (or as a consequence of):	, ,	udden	
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68760, ificata be assected g physician and as the burial-transit edical Examiner	Sequentially list conditions. Due to (or es a consequence of):		Tracs	
e axe e axe urial-	Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or injury			
68760, ificate be axe a physician a sub-burial-ledical Ex	that initiated events resulting in death) Last Due to (or es a consequence of):			
9 5 5	d			
that the death cert ed by the attending detached for use a				
that the de detached is detached in	Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to th		
E X 70	Congestre heart tailure	1 ☐ Yes 2 ☐ No 3 ☐ Probat	bly 4 Unknown	
Shoul	cerchinaralos disease	24a. Wes an autopsy performed? 24b. Were eutopsy available prio completion of death?		
Re lav		1 Yes 2 No 1 Y	res 2□ No	
f Vital Roystolen: The last securificate had director, page	25. Wes case referred to-medical 26. Place of Deeth (Ch.			
Of Vita Physicien: ribis certific and director,	axaminar? Hospital: Other:	5 Rasidance 6 □Other (Specify)	10000	
O L O D O O O O O O O O O O O O O O O O	27. Manner of Death 28a. Dete of Injury 28b. Time of 28c. Injury at 28d. I Naturet 5 ☐ Panding (Month, Day Year) Injury Work?	Describe how injury occurred		
Division of bit of a the death. In or attending P is a feet death. In Director: After the din by the funers Certification:	2 Accident investigation M 1 Yes 2 No			
A AH Herd Herd In by		ocation (Street end Number or Rural R City or Town, State)	loute Number,	
Division Division Hospital or Attending A hours after death. Funerel Director: After stely filled in by the fune silical Certification				
Division or To the Hospital or Attending Ph within 24 hours after death. To the Furerel Director: After this completely filled in by the funeral Medical Certification:	29a. Certifler (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and described in the tima, data and place, and death occurred at the tima, data and place, and death occurred et early mennary stated.	ua to tha ceuse(s) end manner es state tha tima, data and place, and dua to th	ed. a causa(s)	
othe othe omple	end mennar stated. 29b. Signature and title of partifier 29c. License number	29d. Dete signed (Month, De	y, Year)	
OT WELL	be of Mile of a Dissoil			
4	30. Name and address of person who completed causa of death (Item 203) (Type, Print)	JANUARY 12, 1	999	
	Total R MELLICH GIL Rustell And Cont	Husely Mod 2,5	79	
State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura	Y		
Registrar	IAN 1 2 1999 Newer 19 100 11			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 9, January 1999 9:39 AM Dorothy Marie Gooding /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda If Under 24 Hrs. 8 Suburban Hospital Montgomery If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Days Hours 1□M 20XF Months 79 218-03-0079 September 28, 1919 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3607 Dupont Avenue United States Funerai 20895 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indian. Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Town Clerk Town Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Edward Ross Jones Marie Melba Springer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 529 Carr Avenue, Rockville, Maryland 20850 William E. Gooding / son 20b. Plece of Disposition (Name of cometery, cremetory or other plece) January 11, 1999 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M00831 can openience 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MOUTUS Examine Calke Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably Wunknown b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 MNo 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 💥 No Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Neturel 2 Accident 1 Tyes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide

attending physicien and for use as the bunal-transit signed by certificate has Goding, Dorothy Division of Vital this funeral After t r death. Director: 6 ò To the Hospital within 24 hours e To the Funerel C

Physician/Medical Completed Be To Certification:

Funeral

Director

the Maryland

of 2 should be filed within 72 hours after death with the Marylan th end Mental Hygiene.
7 Is marked other then "natural", or items 23s or 28s-f show traumetic event, or Medical Examination until to modified

permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if flem 27 is merked othe eny Injury or other traumests

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

10

29a, Certifier (Check only one) 29b. Signatu

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

| Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year) 9

20852-2736

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

11510 Old Georgetown Road, Rockville, MD

Peter Pushkas, MD 31. Dete filed (Month, Dey, Year)

MAN 1 1

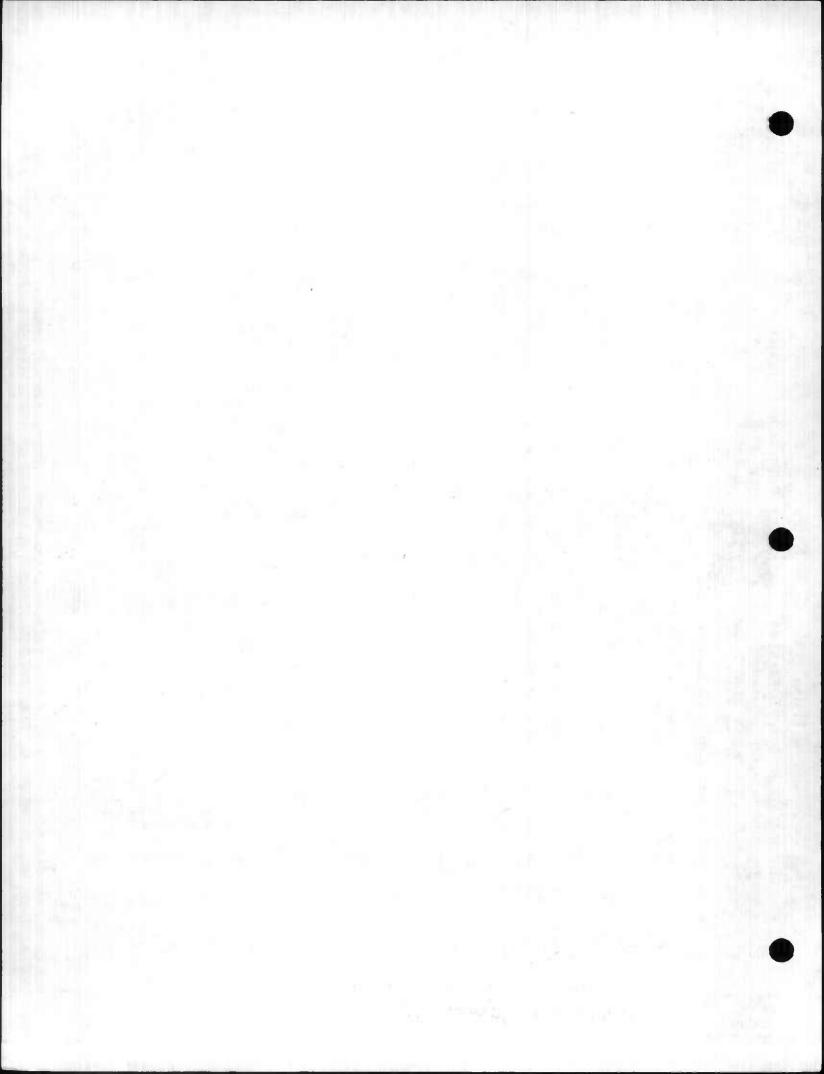
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32. Registrar's Signature

State

Registrar

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dev Month **Physician** HENRIETTA GOTZLINGER 01.06.1999 9:30 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Montgomery Village Care and Rehab. Center Montgomery Village Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. (Month, Dey, Yeer) **Funeral** 10 M & F 92 Yrs. 293.12.4849 CHECZ. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No Director MARYLAND MONTGOMERY MONTGOMERY VILLAGE 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? I is marked other than "natural", or items 23s or traumatic event, the Medical Examiner must be a 19301 WATKINS MILL ROAD 20886 USA pemit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner manal once. Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien Bleck, White, etc. 1 Yes 2 No If Yes, Give X Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: WHITE P 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Neme (First, Middle, Last) LEOPOLD GRUN MARIE POLLICK 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) ALICE GELFAND/GRAND DAUGHTER 7623 MOCCASIN LANE, DERWOOD, MARYLAND 20855 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burlel 2 ☐ Gremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MOUNT COMFORT CREMATORY | 1.8.99 | ALEXANDRIA, VIRGINIA EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licensee 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Physician Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical 20 min Examiner Due to (or es e consequence of): Examine coronary artery disease physician and the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): hypertension Physician/Medical Due to (or es e consequence of): attending pl 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown ky phoscoliosis by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed 1 Yes 24 No 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P funeral 28b. Time of Injury 28d. Describe how injury occurred 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Certification: 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es stated. edical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end menner stated.

Division of Vital Records, P.O. Box 68760,

with the Maryland

The law requires that the death certificate be axecuted signed by the a ils cartificata has b I director, page 2 st or Attending Physician: this To the Mospital or Attending within 24 hours after daath.
To the Funeral Director: Afte completaly filled in by the fun

20

Registrar

30. Name end address of parson who completed cause of deeth (item 23e) (Type, Print) Pollack, M.a

29b. Signeture end title of certifier

809 Viers Mill

29c. License number

Rockille, md

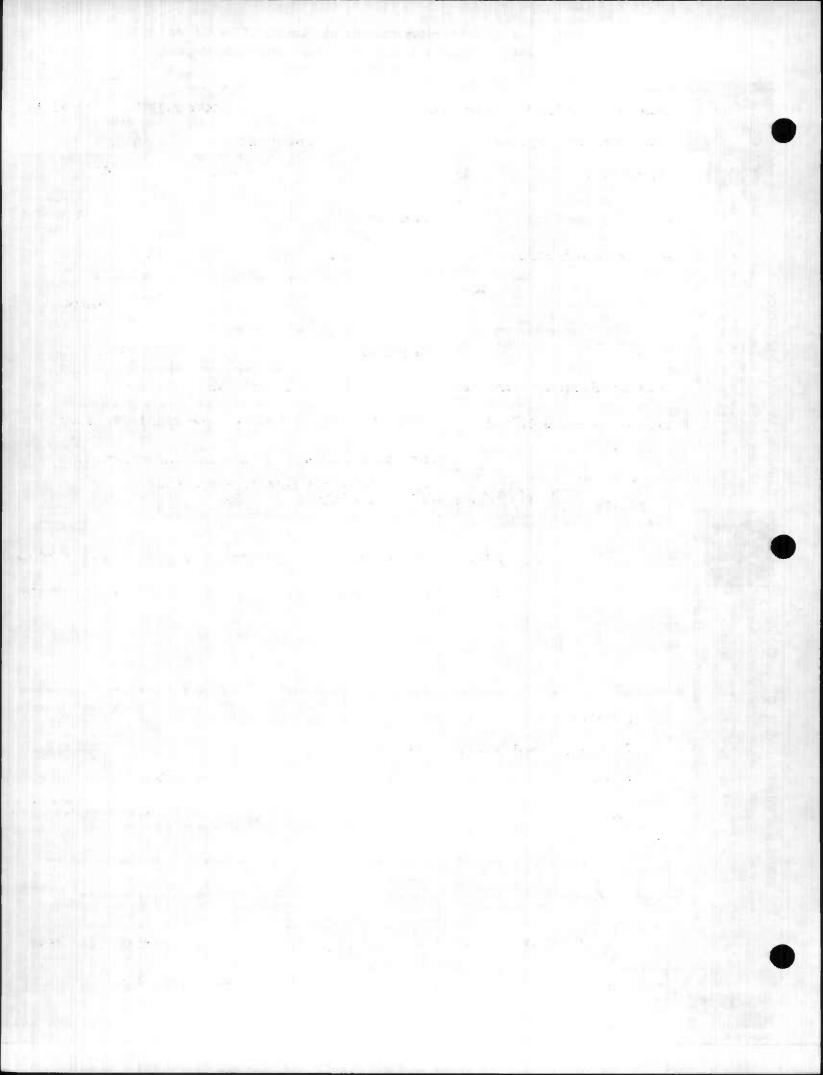
29d. Date signed (Month, Dey, Year)

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 2,1999 11:45 AM FRANKLIN GANNON JR. CHARLES. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Sacred Heart Hospital Allegany Cumberland If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year Mar 2, 19 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours KOM 2DF Yrs. 214-48-2772 47 Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notfilled at NO Yes 2 □ No Cumberland Director Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Springdale Street 21502 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 and 2 should be filed within 72 hours aftar dea Health and Mantal Hygiene. em 27 ia marked other than "naturel", or itema ther traumatic event, its leadest Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) carpentry carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Fanklin Gannon, Sr. Clara Elizabeth Hanley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) permit. Pegas 1 and 2 Department of Health el Important: if item 27 ia any injury or other trau 823 1/2 Virginia Avenue; Cumberland, MD 21502 Richard W. Gross-friend altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 01/03 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Parti. Enter the disease, or complications that caused tile death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) HOUTE MYOCARDIAL TEN MINUTES INFANCTION Examiner Due to (or as a consequence of): Examiner TWENT MINUTES OKONANY THROMBUSIS physician and s the burial-trens Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequenca of): 88 980 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown PHNCREMTITU Division of Vital Records, A 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed peen CHRONIC MALNUTRITION completion of ceuse of death? has paga 2 DISENSE CROTTNS 1 Yes 2 No certificate 25. Was case referred to medicel examiner? Attending Physician: funeral director. Be 26. Piace of Death (Check only one) EXTENDEN Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) CARE UNIT Lo 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describa how Injury occurred Certification: 28b. Time of 28c. injury at Work? 1 Naturai 5 Pending al or Attending after death. I Director: After 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or Atte
 24 hours after de
 Funeral Directe
 letaly filled in by t 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completaly f (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 🙏 1999 ワヌ3Y1つ w 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 2 1068 NATIONAL HUY-21502 CAVALE, MD JAMES R. MIEN, MA. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar IAN 0 5 1999

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygien

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month : 22 Pr ESSIE L. January **GOUKER** 4, 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death W. Patrick St. Parking Lot of Fredericktowne Mall, Frederick Frederick If Under 24 Hrs. Hours | Min. If Under 1 Yea 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 2XF Months Deys 72 213-24-9444 Dec. 26, 1927 Maryland Usuei Residence of Deceden 10e. State 10b. County 10c. City. Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2716 Canada Hill Road 21773 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondary (0-12) Coltege (1-4or 5+) 12 supervisor telephone/utilities 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Herman Hensler Mabel L. Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742 Michael Gouker, step-son 13513 Olde Saybrook Circle, Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 XBurial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Mt. Olivet Cemetery 1/14/99 Hagerstown, Maryland 21. Signature of Funerat Service Licensee 22. Name end Address of Fecility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that dated the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feiture. List only one cause on each tine. ·Di Approximete Intervat Between Onset and Death Immediate Ceuse (Finat disease or condition resulting in deeth) Yea-15 Due to (or as e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Type 2 No 3 Probably 4 Unknown 24b. Were autopay findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitat: 12 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Parking Lot 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Yea 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suiclde 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homtcide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. (Check only one) 29b. Signature and tifle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35164 January 7, 1999 30, Name and address of person who completed cause of death Item 23e) (Type, Print) 1080 W. Patrick St Fredorick MD 21703 SM ndie 32. Regist ar's Signeture

State Registrar

31. Date filed (Month, Day, Year)

Physician

Examiner

Funeral

Director

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Division of Vital Records, P.O. Box 68760,

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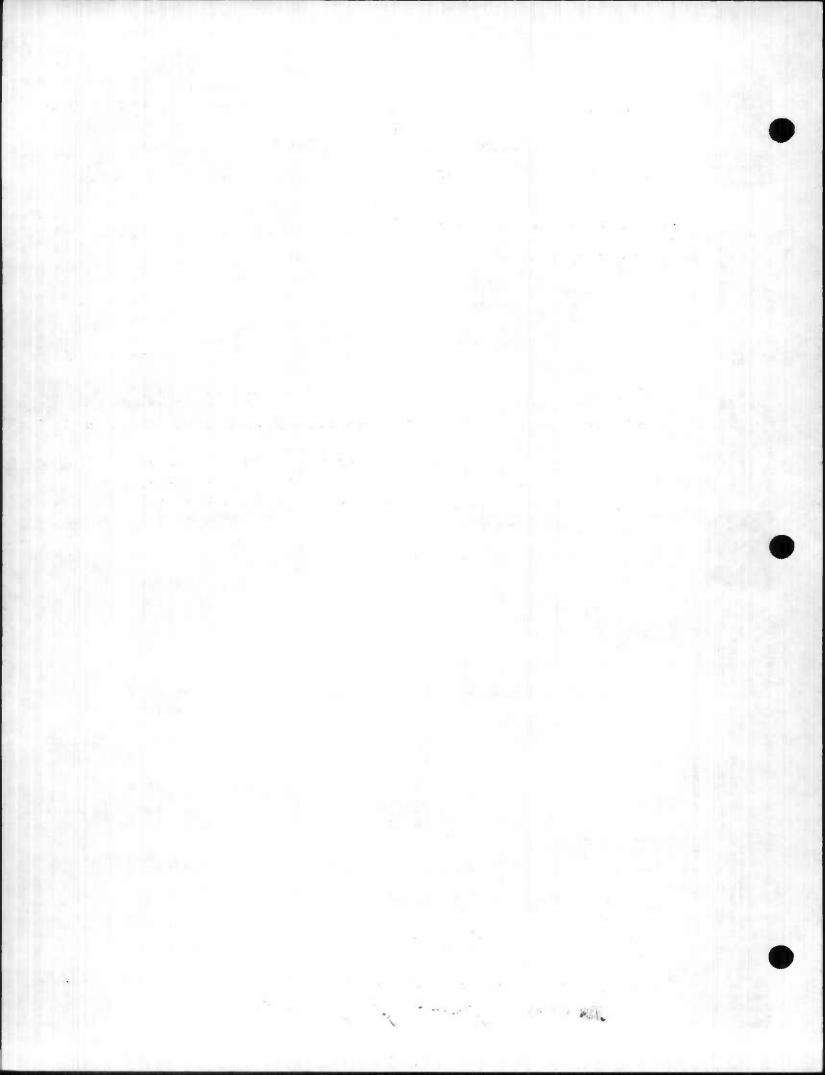
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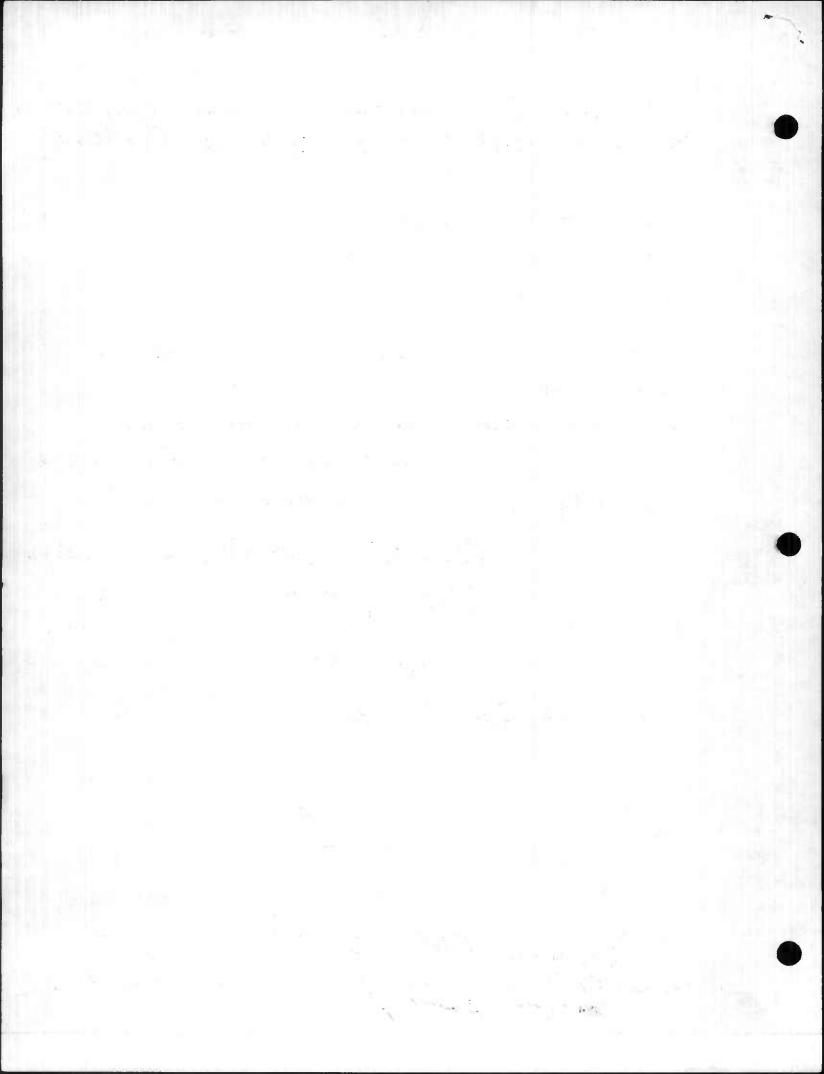


Amended line 20b, FCHD, KS Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** GRABLE TANUARY 1999 0450 AM /Medical 4a. Fecllity Nema (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 16 5. Social Security Number Undar 1 Year Under 24 Hrs. 7. Age (In yrs. **Funeral** 1 M 2□ F Months Days Hours Yrs. Director 215-20-8070 76 10, 1922 Maryland Feb. Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itams 23a or 28a-f show traumetic event, the Medical Examiner must be multified at 1 Yes 2 No Director Maryland Frederick Thurmont 10e. Street end Numbar 10f. Zip Code 10g. Citizen of Whet Country? by Funeral Box 3, Orndorff Road 21788 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Ricen, atc.) 14. Rece - American Indian, Bleck, Whita, etc. filed within 72 hours after 1 Navar Married 2 Merriad 1 X Yes 2 No If Yes, Give Yeer or Datas: WWII 21215-0020 1 Yes 2 No Specity: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Laborer Construction Maryland Pages 1 end 2 should be file ment of Health end Mental Hy ant: If Item 27 Is marked oth 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Daniel Grable Clara Mae Kauffman 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health e Important: If item 27 is any injury or other tra Irene H. Wastler, daughter 8604 Orndorff Road, Thurmont, MD 21788 Baltimore, 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 1/5/98 Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funerel Sarvice Licenses 22. Nama and Address of Fecility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Pert1. Entar ha diseese, or complications thet cause the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each no Approximete Intervel Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) pital or Attending Physician: The lew requires that the death certificate be executed ours elder deeth. The literator: After this certificate has been signed by the ettending physician end filled in by the Innestal frector, page 2 should be deteched for use as the burnel-transit Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uea contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No þ 24b. Were autopsy findings aveilebla prior to completion of causa of deeth? 24a. Wes en eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 25 No Other: Nursing Home 5 Residence 6 Other (Specify) 0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Menner of Deeth 28a. Dete of Injury (Month, Dev Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred Naturet 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Suicide 28e. Plece of Injury - At home, ferm, straet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Sertifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.

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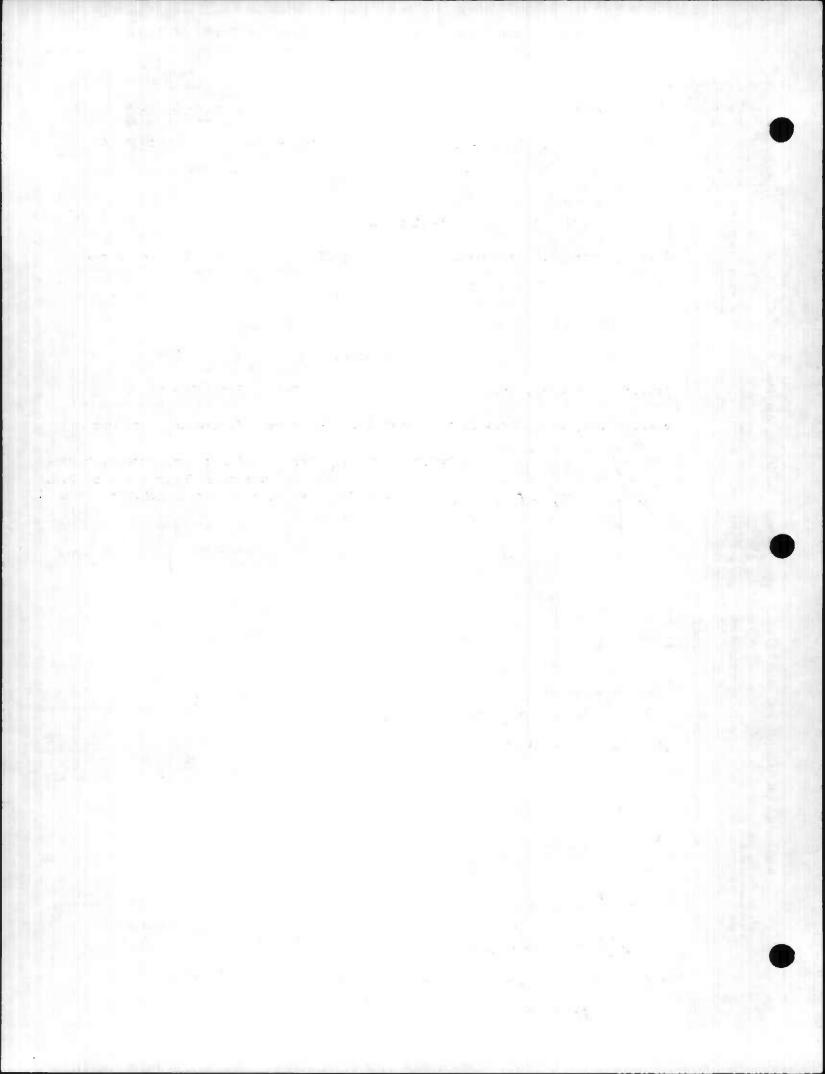
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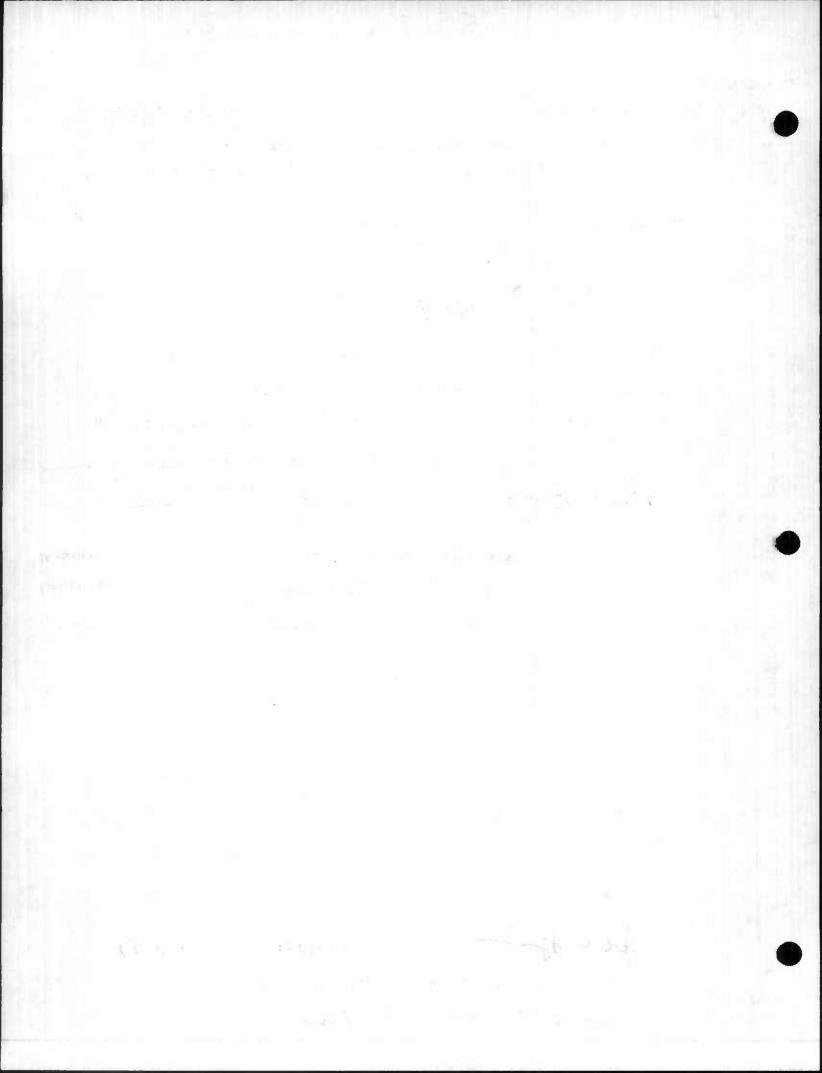
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State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Dev /Medical Leonard Holland January 08 1999 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** The Kent & Queen Anne's Hospital Inc. Chestertown K
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Deys Yrs 214-32-1537 Director 64 Mar. 9, 1934 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Kent Chestertown 10e. Street end Number 10f, Zip Code 10g. Citizen of Whet Country? 5 Items 23a Funeral 104 Kennedy Drive USA 21620 12. Wes Decedent Ever In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. Bieck, White, etc. 72 hours efter 1 XYes 2 No If Yes, Give Yeer or Detes:///56~6/59 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural', or 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black. Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 6a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12th Chauffer Heron Pt. (Self Emp.) marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health end Mental Hant: If item 27 is marked oth lury or other traumatic even Be 0 Ernest Holland Martha Hayman 19e. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Joyce Holland, wife 104 Kennedy Dr., Chestertown, Maryland 21620 20e. Method of Disposition 20b. Place of Disposition (Neme of cametery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ☑ Burlai 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veteran's Cem. 1/13/99 | Beulah, Maryland ature of Funeral Servica Licensee 22. Name end Address of Fecility Bennie Smith Funeral Home Muce P.O.Box 1687, Easton, Maryland 21601 a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest hock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician immediate Ceuse (Finel diseese or condition resulting in death) /Medical 4) Herry CHANDINE DOMPCHANE Examiner Due to (or es e consequenca of): Examiner 48 Itzens MACIENAT PENKAMINS The law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieled events resulting in death) Lest Due to (or es e consequenca of): Box 68760. MOTOTIONIL COLLY CYNEW Physician/Medicai the Due to (or es e consequenca of) use as P.O. Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown ate hes been signed pege 2 should be del Records, Completed by 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) exeminer? Hospitel: 1 Ninpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Menger of Deeth 28e. Dete of Injury (Month, Dev Yeer) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury et Work? Division After 5 Pending investigation 1 Neturei death. 1 ☐ Yes 2 ☐ No 2 Accident spital or Attendi cours efter death weral Director: A 6 Could not be determined 3 Suicide 28e. Pieca of injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. Medical 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 17-138-24 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) John C. Seymour M.D., 100 Brown Street, Chestertown, Maryland 21620 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

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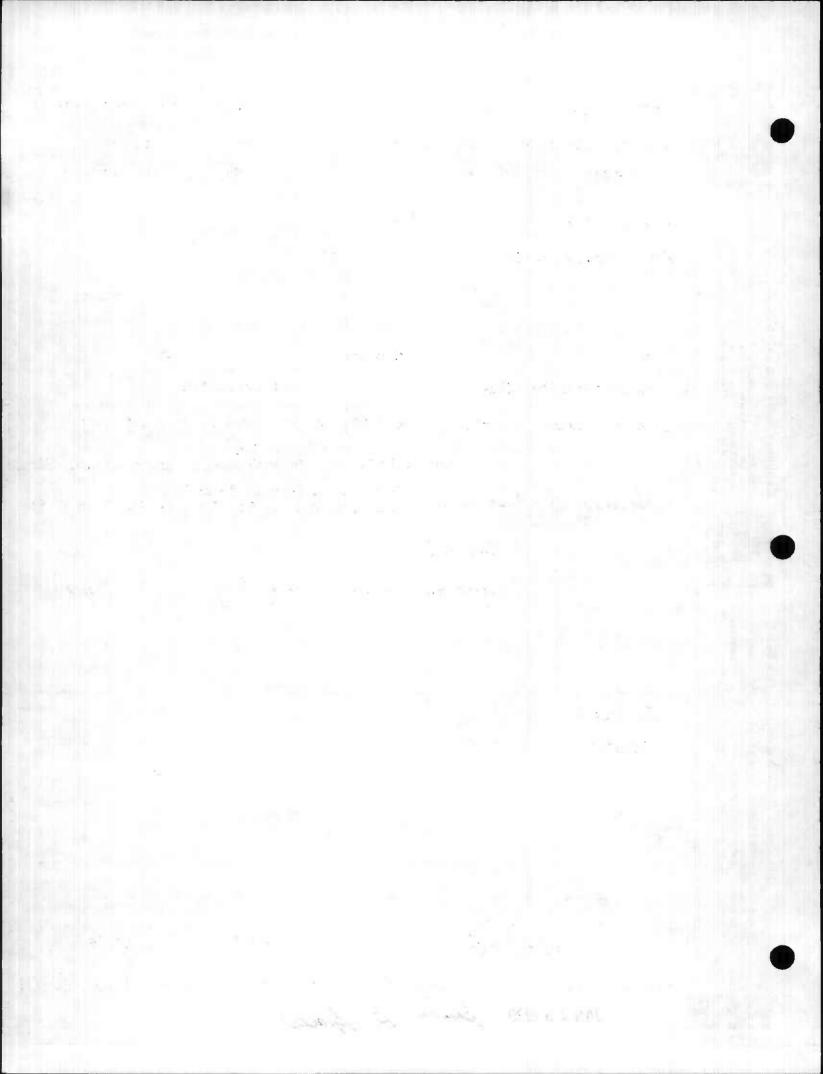
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	Usuel Residence													
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Be Completed	17. Father's Name	(First, Middle, Li	ast)					18. Moth	er's Na <i>me</i>	(First, Middle,	Maiden Su	mame)		
To	Thoma	s Arnold	Makibl	bin				Li	llia	n Martin	n			
	19a. Informant's N	leme/Relationshi	p (Type, Print)		19b. M	lailing Add	ress (Street	t end Numb	er or Rura	i Route Numbe	r, City or To	own, Sta	ate, Zip C	Code)
	Edgar W	. Haddav	vav l	Nephew	29	214 P	in Oa	k Way	E	aston, I	Warv1	and	2160	01
	20a. Method of Dis		iay .		Dian of Di	Innanialan /	Alama of				20c. Locat			
		☐ Cremation 3		om State	cemetery,	crematory	or other pe	aster	n Sh	ore				
	21. Signature of F	5 ☐ Other (Spe		IVI:	arylan	d Vet	erans	ess of Facili	tery	Jan. 1	5, 19	99 F	Jurla	ock, Md
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State of Maryland / Department of Health and Mental Hygiene

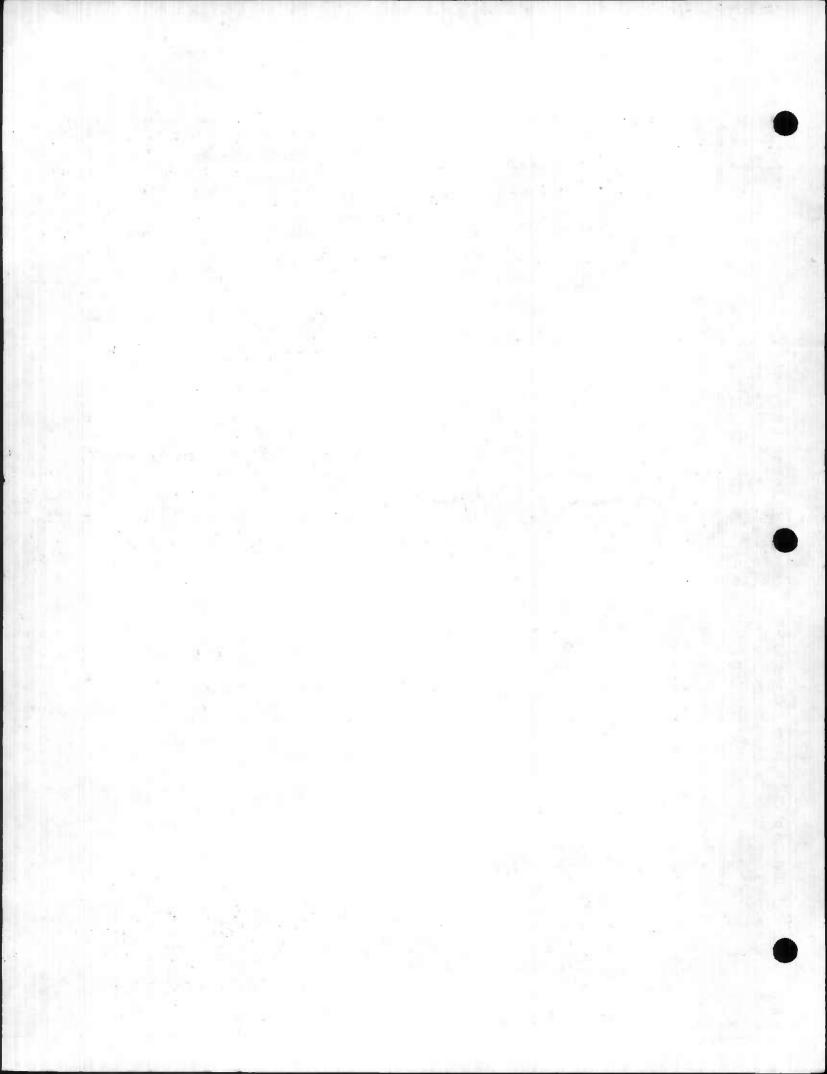
Ш	ט	irect
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland. Department of Health and Mental Hydians.	Important: if Item 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at
	Phy /M Exa	sicia edic min
Division of Vital Records, P.O. Box 68760,	of or Attending Physicien: The law requires that the death certificate be executed after death.	Ofrector: After this certificate hes been signed by the ettending physician and d in by the funeral director, page 2 should be deteched for use as the burial-transit

ы					Cei	tificate	of L	Death		,	Reg. No	99	0	15	78
	1. Decedent's No	ame (First, Middle, La	ist)						2	. Data of De Month		av.	Year	3. Tim	a of Death
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niner	4a Facility Name	a (If not institution, given	e street and num	ber)			4	b. City, Town	n, or Loca	tion of Deat	h 40	. County	of Death		
	CARROLL	COUNTY G	ENERAL				V	WESTMI	NSTE	R	C	ARRO	LL		
al	5. Social Security		Sex 7	. Age (In yrs.	. last birthday)	If Under 1 \	Year Days	If Under 24 Hours	Hrs. 8	Data of Bir (Month, Da	th v. Year)	9. Birthp	place (Sta	nte or Foreign
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		Name/Relationship (g Address (S									21150
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	20a. Method of E	Disposition 2 ☐ Cremation 3 ☐	Removal from S	tata	cemetery, cren	natory or other	r place			Data			City or To		
		n 5 ☐ Othar (Specia		Ва	ust Ch	urch	Ce	m. 1/	17/9	9	Wes	stmi	nst	er,	MD
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Physician/	Part II. Other sig	nificant conditions	ontributing to dea	th but not res	sulting in tha ur	derlying caus	sa give	en in Part I.		23b. Dld	1obacc	o use cor	ntribute to	o the cau	se of death?
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	27. Manner of De		28a. Date of	7,000	28b. Tima of Injury		Injury	at	28	d. Describe	how inju	iry occurr	ed		
1	1 Matural 2 Accident	5 ☐ Pending invastigation		,,	ti ijai y	М		Yas 2 □ No	0						
	3 ☐ Suicide 4 ☐ Homicid	6 Could not be determined	28a. Place C	of Injury - At h	noma, farm, str	et, factory, of	ffice		28	f. Location (er or Rure	Al Route	Vumber,
Certification:	→ □ nomicio		building	g, atc. (Speci	(y)					City or To	wii, Siel	4)			
Palical	29a. Certifier (Check only one)	1☐ Certifying Ph 2☐ Medical Exar	ysician: To the bas niner: On the bas and manna	is of examina	owledge, death ation and/or inv	occurred at t	ha tim my op	a, data and pointion, death	place, and occurred	d dua to tha at the time,	cause(s	s) and ma nd place, a	nnar as s and due to	tated.	sa(s)
2	29b. Signature a	nd titla of certifier	· na			29c. L	icense	number			29d. Da	ata signed	(Month,	Day, Yes	ar)
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	30. Name and ad	Idress of person why	completed cause	of death /tree	m 23a) (Tyne I		O . I	1.1.			21 HAO	A SALVA	0,10.		
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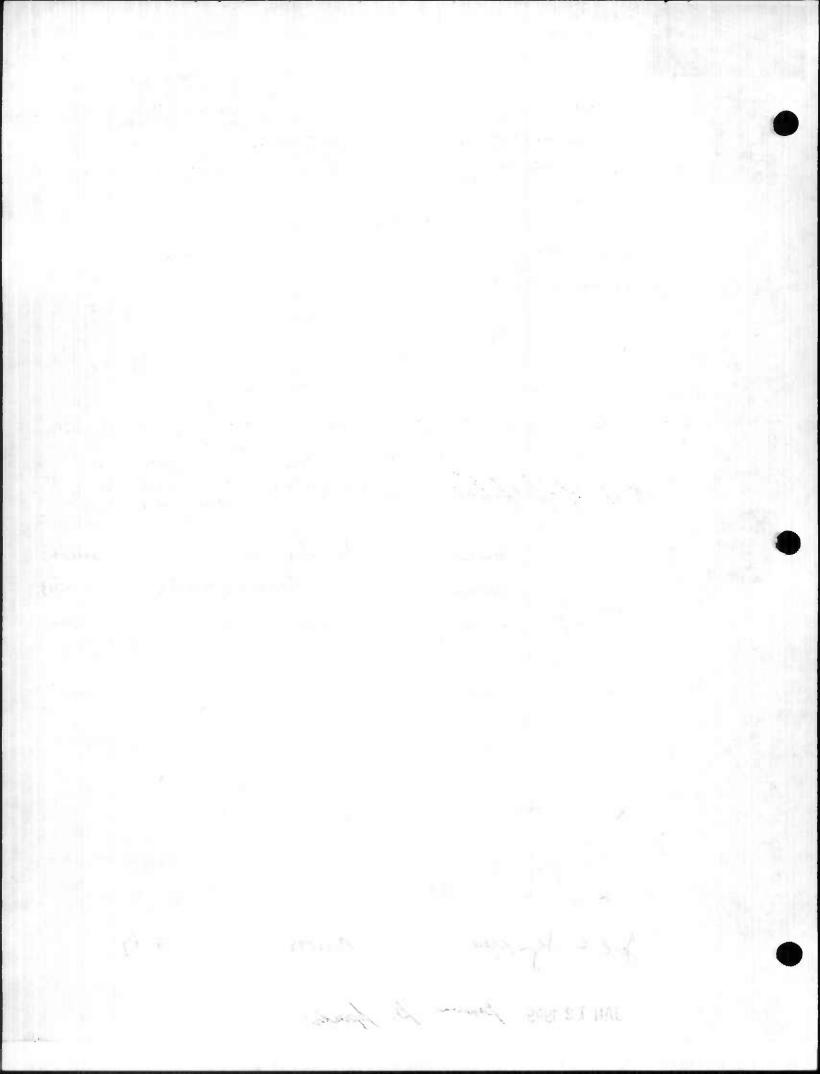
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	1	Decedent's Neme (First, Middle, Last	st)		Certif			2. Dete of Deet	eg. No. h	2	Time of Deeth
Physician /Medical		Thomas Bolton Hari Fecility Neme (If not institution, give	rison				Ab Ciby Tarre	Month January	8, 1999	Yeer C	400 hrs
Examiner		6115 Tolchester Ro		omo)			4b. City, Town, or I		4c. County		
Funeral Director				e (In yrs. last		Under 1 Year onths Deys	Rock Ha If Under 24 Hrs. Hours Min.			9. Birthplece Country) Alaba	(State or Foreig
M III	-	10e. Stete 10b. County		10c. City, T	own or Location	on				10d.	nside City Limit
to to	[]	Maryland Kent		Roc	k Hall						☐ Yes XXN
or 28a-fig be notified		10e. Street end Number				Of. Zip Code		16	0g. Citizen of V	Whet Country?	
234		6115 Tolchester Ro	oad			216	561		United	States	
alical Examiner, need to 28a-1 show alical Examiner, must be notified at steed by Funeral Director	3	1 Maritel Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decadent I Armed Forces? 1 ☐ Yes 2424 If Yes, Give Year or Detes:	Ever in U,S.		Decedent of H s, specify Cube Yes 2XXXIO	lispenic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - American in kk, White, etc.	
ygiena. ner than "natural", nt, the Medical Ex.		15. Decedent's Ed (Specify only highest gre	ucation de completed	1	6e. Decedent's	s Usuel Occup	ation during most of wor	tina	16b. Kind of Bu		
r than "		Elementery/Secondary (0-12)	College (1-4or 5	+)	life. DO N	VOT use retired	during most of wor	King			
other trends of the Cor	5	12	4		Proof	Reader			Newspar		
20 0 m	1	17. Fether's Neme <i>(First, Middle, Last)</i> Chomas Bolton Harr	cicon					ne (First, Middle, N	Maiden Sumem	ne)	
markad matic e		19e. Informent's Neme/Reletionship (7			IOh Mailine A	ddrago (Chroat	Ethel E		O1 T	0	da -
20.00		Edna Lorraine Harr					end Number or Ru				
tam 27 other tr		20e. Method of Disposition		20b. Place	of Disposition	CHESTE n (Neme of	er Road, January	KOCK Hal	L, Mary	City or Town,	21661 Stete
Depertment of Her Important: If Itam any Injury or othe once.		1 ☐ Burial ②XCremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify									
Depertment (Important: If any Injury or once.	-	21. Signature of Funeral Service Licen		ulesap	22. Na	me end Addre	enter, IIC		Chester,	Marylan	d
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	+	23e. Pert1. Enter the diseem, or como	oliceti vis thet ceused	the death [130	Speer F	Road, Che	stertown	. Marvl	and 2	1620 proximete
ysician		23e. Pert1. Enter the diseed, or only on shock, or heart faiture. List only of	one cause on each lin	е.		o mode or ayiii	9, 000, 00 00, 000	or reaphrotory one	,	inte	rval Between set end Deeth
Medical		mmediete Ceuse (Finel disease or condition	Alla	7- 1.	In.	100 121 1	Shilan				1142-1
aminer		resulting In deeth)	e. //cc/	Due to (or es	e consequence	ce of).	Pur Lui	2		1 20	ices
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g physician and as the bunal-transit		Sequentielly list conditions,	U		e consequenc						, , , ,
yan a		Sequentielly list conditions, fery, leeding to Immediate ceuse. Enter Underlying Cause (Disease or Injury	School	uc e	mnee	yenun	Wi			109	come
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atached for use	F	ert II. Other significent conditions co	entributing to death bu	t not resultin	g in the under	ying cause give	en In Pert I.	23b. Did tol	oacco uaa con	ntribute to the	causa of deat
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been signed by the ettand should be datached for us. ieted by Physician/					18			24a. Wes er	eutopsy	comple	utopsy findings le prior to
shou	1-						*	periorn		of doot	tion of ceuse
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rier death. Irector: After this certificate has n by the funeral director, page 2 rtification: To Be Comp	2	exeminer? 1 Yes 2 No 7. Menner of Deeth 1 Neturel 2 Accident 3 Suicide 4 Homicide 1 Certifying Phyone)	28e. Dete of injur (Month, Day 28e. Plece of Injur building, etc.	Year) 28t	o. Time of Injury N ferm, street, f	28c. Injury Work 1 1 2 ectory, office	er: 4 Nursing H	th (Check only one ome 5 Resider 28d. Describe ho 28f. Location (Str City or Town, end due to the ce red et the time, de	eet end Number State) use(s) end mei te end place, a	ar (Specify) ed er or Rural Rol nner as steted	s 2 No
in 24 nous and chosant. Perunate Director. Astar this certificate has pletaly filled in by the funeral director, paga 2 edical Certification: To Be Comp	2	exeminer? 1	28e. Dete of Injur (Month, Day) 28e. Plece of Injur building, etc. etclen: To the best of end menner stell	Year) 28t	o. Time of Injury N ferm, street, f	28c. Injury Work 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	er: 4 Nursing H	th (Check only one ome 5 Resider 28d. Describe ho 28f. Location (Str City or Town, end due to the ce red et the time, de	eet end Number State) use(s) end mei te end plece, sid. Dete signed	ar (Specify) ed er or Rural Rou nner as steted and due to the	s 2□ No ute Number,
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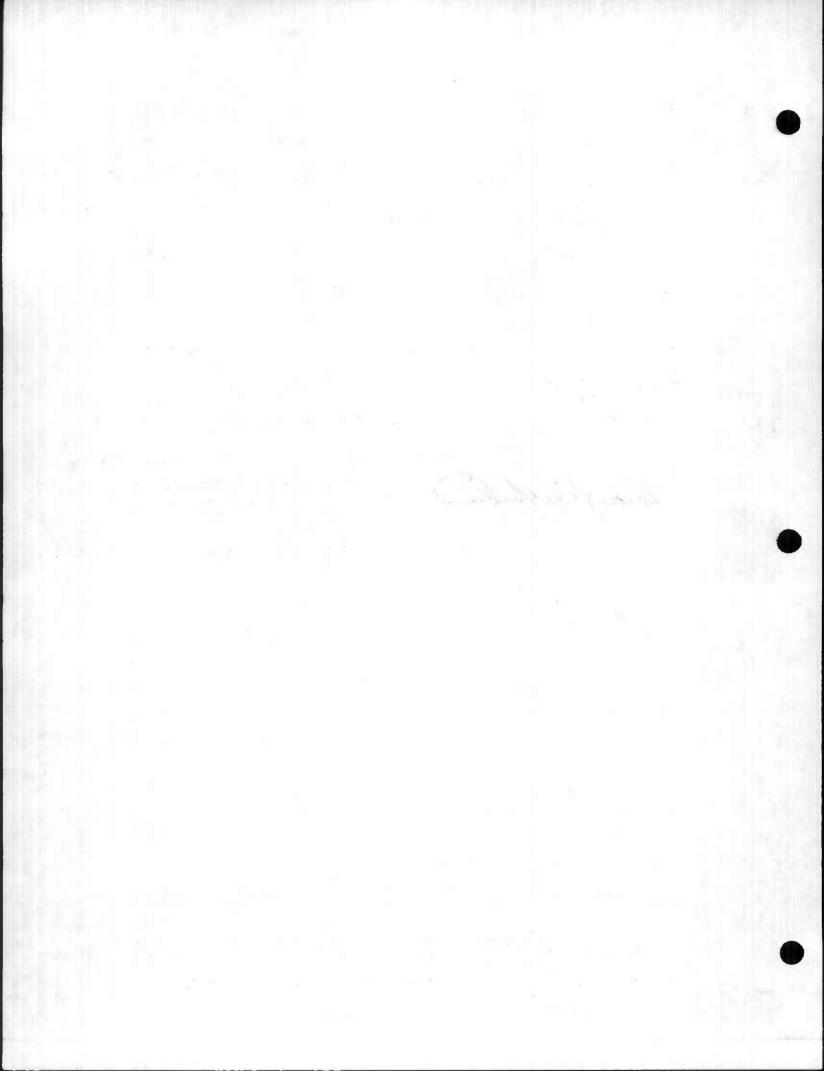


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of IV	iaiyiaii		tificate of	Death	wentar ny	Reg. No.	0	1580
П	Physic	ian	Decedent's Name (First, Middle, I					160	2. Date of De	eath Dey	Year	3. Time of Death
ı	/Medi		Vera L. (I.O.) 1						January	8, 1999		1120 hrs
	Exami	ner	4e. Facility Name (If not institution, g	lve street end number)			4b. City, Town, or				
-			Schuyler House 5. Social Security Number 6.	Sex 7. A	ne (In ure	lest birthdey)	If Under 1 Year	Church H			en An	
	Funeral Director		212-20-2344 Usual Residence of Decedent	1□ M 2只 F	92	Yrs.	Months Days			24, 1906	9. Birthp Coun Pen	lace (Stete or Foreign htry) Insylvania
	/land		10a. State 10b. County		10c. City	y, Town or Loc	ation				11	0d. Inside City Limits
	the Marylan 28a-1 show	tor	Maryland Queen	Anne's	Cl	hurch H	Hill					1 Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Coun	itry?
	ath w		Walnut Street - I	30x 93			21623			United	Stat	es
21215-0020	be filed within 72 hours after death with the Maryland lat Hygiene. I dother than "naturet", or items 23a or 28a-f show event, the Medical Evanner must be northed at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ሺ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates:	?	If	as Decedent of Yes, specify Cul	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or Norto Ricen, etc.)	Specify	a - Americ ok, White,	etc.
2-0	72 ho	ted	15. Decadent's (Specify only highest g			16a. Decede	ent's Usual Occu	petion a during most of wo	action	18b. Kind of Bu		
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			ed)			, -	
	e filed wall Hygier outher th		17. Father's Name (First, Middle, Las	141		Homema	iker	40 1444		Domestic		wn Home
Maryland		Be	James B. DeHaven	51)				Clara L	me (First, Middle	en Name	,	own)
ary	d 2 should b th and Mente 7 is merked traumatic e	To	19e. Informant's Name/Reletionship	(Type Print)		19h Mailing	Address (Stree	at end Number or F				
	4434		Evelyn Grehawick					l Road,	Church E	Hill Man	cul on	d 21623
re,	- 7 5 5		20a. Method of Disposition		20b. Pl	lace of Dispos	ition (Neme of		Date	20c Location - 1999	City or To	wn, State
E	Page lent on nt: If ry or		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from Stata	St.		etory or other pla Ceme te	rv Janu	ary 13,			
Baltimore,	pemit. Pages Department of I Important: If ite any Injury or of		21. Signature of Funeral Service Lic	1 1 1	1	22.	Name and Addr	ess of Facility				Maryland
m	Depariment Important Information		William L. Ki	g. Jr. M	1003							ome, P.A.
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	- had a	d the death	Do not ente	the mode of dy	lain Stre	et, Ceci c or respiratory a	rrest, Ma	ryla	Approximate
	Physician		STOOK, OF HOUR TAILUTO. LIST OFF	y one diameter i	me.						1	Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Finel disease or condition	& CERE	BRD	VASC	LLAR	ACCIT	DENT			3 days
Е	Examine:	_	resulting in death)			r as a consequ					1	
	pet nsit	Examiner		b								
	ficate be executed physician and as the burial-transit	xar	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury		Due to (or	es a consequ	ence of):					
68760,	a be	edical	thet initiated events	c	Due to for	as a conseque			<u> </u>		1	
	*E D 65		resulting in death) Last		Due to (or	as a conseque	erica or):					
Вох	attending for use	an		d								
	the death cer y the attendir sched for use	Physician/M	Part II. Other significant conditions	contributing to death b	ut not resu	ilting in the und	derlying ceuse gi	iven in Part I.	23b. Dld	tobacco use cor	ntribute to	the cause of death?
0.		Phy							10	Yes 2 No	3 Prob	eably 4 Unknown
	8 50	by										
DIVISION OF VITAL Records,	neen	Completed								an autopsy rmed?	ava	ere autopsy findings ailable prior to apletion of cause
9	8 8 CA	mpi									of c	death?
ā	E ata								10	Yes 2 No	1 🗆	Yes 20 No
=		Be c	25. Was case referred to medical examiner?	Hospital:			_ Ot	CAD	eth (Check only of E HOME)			
0	Phys ral di	1: To	1 ☐ Yes 2 ☑ No 27. Menner of Death	1 Inpatie		ER/Outpatient 28b. Time of	3LI DOA	40 Nursing	Home 5 ☐ Resi	denca 8 Other)
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5	s after s after al Direct ed in by	Certification:	4 Homicide	building, et	c. (Specify))			City or To	vn, Stete)		
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 CertifyIng P. 2 Medical Exa	hyaician: To the best	examinati	viedge, death o on end/or inve	occurred et the ti stigation, in my o	me, date and plec opinion, deeth occ	e, and due to the urred at the time,	cause(s) end me dete end place, e	nner es ste and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier	and manner st	o.eu.		29c. Licens	se number		29d. Date signed	(Month, I	Dey, Year)
	->-0	7	b the 181	Duly ins	0		Di	41587		1/5	2/00	2
		-	30. Neme and eddress of person who			23a) (Type Pi		11307		'/	177	/
	Mag 5		Helen Noble, MD,					Maryland	1 21620			
	Sta	te	31. Date filed (Month, Dey, Year)	32. Registr		ure /	1					
	Registr	ar	JAN 121	999		1.	Sport	2				

State of Maryland / Department of Health and Mental Hygiene 9 0 1 5 8 1

							Death	1		Reg. No.		
	_	1. Decedent's Name (First, Middle, La	ast)	•					2. Dete of De	eth	V	3. Time of Death
hysician /Medical	_	Ethel Borg Harrin	ngton						Month January	2, 19	Yeer 99	3:20 AM
Examiner	1	4e. Fecility Neme (If not institution, gi		nber)			4b. City, To		ation of Deeth		ty of Deeth	
.,	۱	Corsica Hills					Centi	revil:	10		n Anı	
ineral			Sex	7. Age (In yrs.	lest birthday)	If Under 1 Yea				h Quee	9 Birth	nlece (State or Fore
rector			1□M 2XXF	8		Months Deys	Hours	Min.	(Month, Da)	V. Year)	Col	nplece (Stete or Foreigntry) New York
	-	Usuel Residence of Decedent			0				OVGILLEL	7, 1912	PLOI	ix, new ro
No ma		10e. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Llm
28a-f show octified at	2 1	Maryland Queen A	nno t c			277-						1X Yes 2□
be notified	3	10e. Street end Number	шев		entrev	10f. Zip Code				10- 0%	140-4-0	
	5						-			10g. Citizen of		intry?
rai i	4	205 Armstrong Ave				2161				USA		
then 'natural, or liems 23s or 28s-1 sho the Medical Examiner must be notified at ompleted by Funeral Director		11. Maritel Stetus	Armed Fo	ident Ever in U rces?	,S. 13.	Wes Decedent of If Yes, specify Cu	Hispenic Or ban, Mexice	rigin? (Spec n, Puerto R	rify Yes or No- licen, etc.)	14. Re	ca - Amer ack, White	icen Indien, , etc.
by F		1 Never Married 2 Married	1 ☐ Yes If Yes, Giv			1□ Yes 2☐N	Specify:	•		Speci	y: Whi	ite
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nt, the Medical I		15. Decedent's E (Specify only highest gra	ducetion ade completed)		16e. Deced	dent's Usuel Occu kind of work done DO NOT use retir	upation e during mos	st of workin	a	16b. Kind of E	Business/I	ndustry
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		12	4		Accou	ntant			Ī	HealthC	are	
metic event, the M		17. Fether's Neme (First, Middle, Last	'				18. Mothe	er's Name	(First, Middle,	Maiden Sume	me)	
atic e	E	Francis Edward Box	rg				Elsie	Sch	ıtz			
traumatic TO		19e. Informent's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Stree				r, City or Town	n, State. Zi	ip Code)
N b		Sue Leager				owell St				-		
E e e		20a. Method of Disposition		20b. F	Plece of Dispo	sition (Neme of	وناعانا	Jene	Dete	20c. Location		
any Injury or o		1 Buriel 2 □ Cremetion 3 □		State	_	esition (Neme of metory or other pl	ece)				-	
in j		4 ☐ Donetion 5 ☐ Other (Special 21. Signeture of Funerel Service Lices		De	nton Ce				/6/98	Denton	, Mar	Home, P.
in and included in the second in the second included in the second in the second included in the second in the sec		disease or condition resulting in deeth)		Due to (d	or es e conseq	REN/ quence of): NUS/ quence of):		DISE	, HSE			ZWKS
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Tima of Deeth Month Day GERTRUDE ALICE HOWSARE JANUARY 5,1999 10:40 p.m. 4e Fecility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND

If Under 24 Hrs. ALLEGANY If Under 1 Yaar 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days Min. 1□M 2♥F Months Hours 220-10-7783 87 Yrs W. VA. Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes ¾XNo BEDFORD BEDFORD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. RFD# 3 15522 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give A Yaar or Datas: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, atc.) 14. Rece - American Indian, 11. Meritel Status Black, White, etc. 1 Navar Marriad 2 Marriad 1 Yes 2 No Specify: Specify: WHITE 3K Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) LION MANUFACTURING CO. MANUF. 18. Mother's Name (First, Middle, Maidan Sumama, 17. Father's Neme (First, Middla, Last) AMANDA E. LANDIS DAVID KIMBLE 19b. Mailing Address (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Reletionship (Type, Print) 21502 DAUGHTER 1237 W. BRADDOCK ROAD LAVALE MARYLAND RUTH ANN GILLUM 20b. Plece of Disposition (Nama of cematery, crematory or other place) Dete 20c. Location - City or Town, Stata 20e. Method of Disposition ©Burlal 2 ☐ Cremetion 3 ☐ Removel from Stete SUNSET CEMETERY JANUARY 8 1999 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nama end Address of Fecility MERRITT-ADAMS FUNERAL HOME 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel diseese or condition resulting in death) 3 days Sepsis Due to (or es e consequence of): 5 days Pneumonia Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware autopsy findings evailable prior to 24a. Was en eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23s or 28s-f show Examiner must be notified at

'natural', or

be filed within 7 ial Hygiene.

permit. Peges 1 and 2 should be file Department of Health end Mental Hy Important: If flem 27 Ia marked othe any injury or other traumatic event, once.

traumatic event, the Medical

Director

Funeral

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Completed

the Marylend

death

72 hours after

Maryland 21215-0020

Baltimore,

physician end the burial-transit law requires that the death certificate be executed Box 68760, attanding 9SD 0 ed by the a signed by t peen : paga 2 s Hes The certificata funeral director. this After

of Vital or Attending Physicien: Division daath. aftar To the Hospital of within 24 hours a To the Funeral D

HOWSER, GERTRUDE

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Director:

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29e, Certifier

State Registrar

Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. by Completed completion of ceuse of death? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Chack only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide

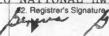
920 NATIONAL HWY, LAVALE, MD 21502

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

VIK POONAT, M.D.
31. Dete filed (Month, Day, Year)

JAN 0 7 1999

29b. Signetura end title of certif



15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steled.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and manner stelad.

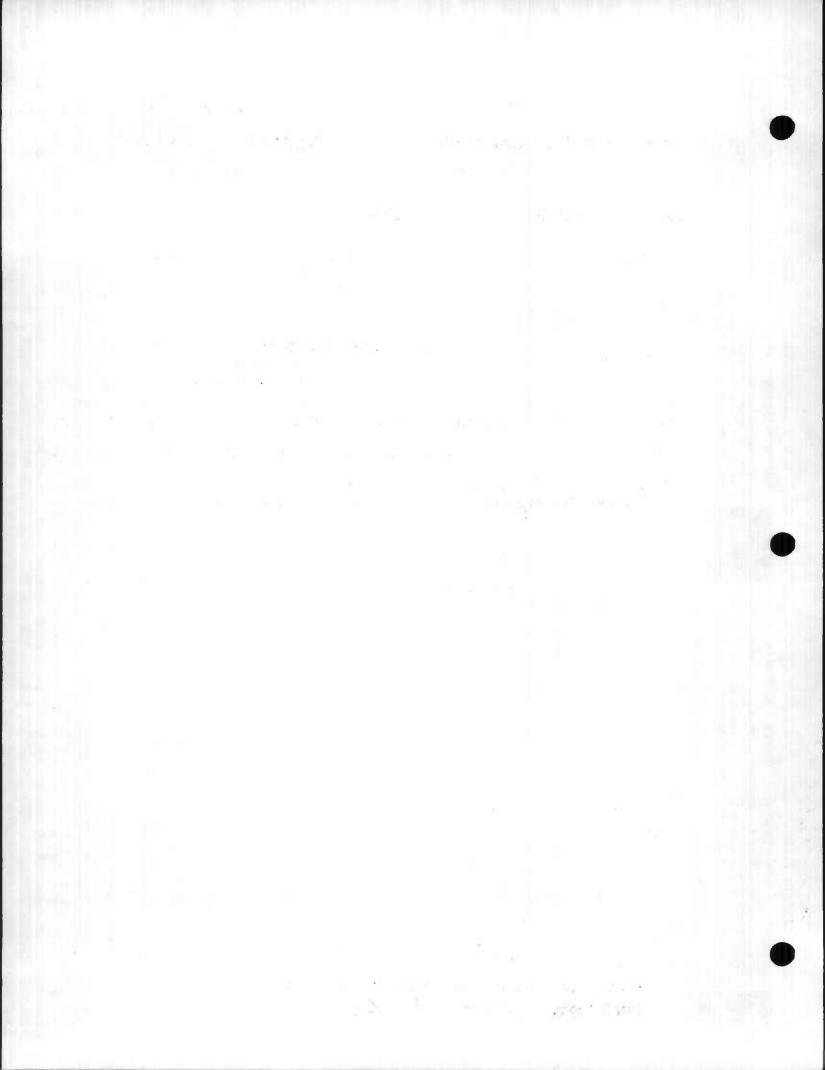
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29d. Data signed (Month, Day, Year)

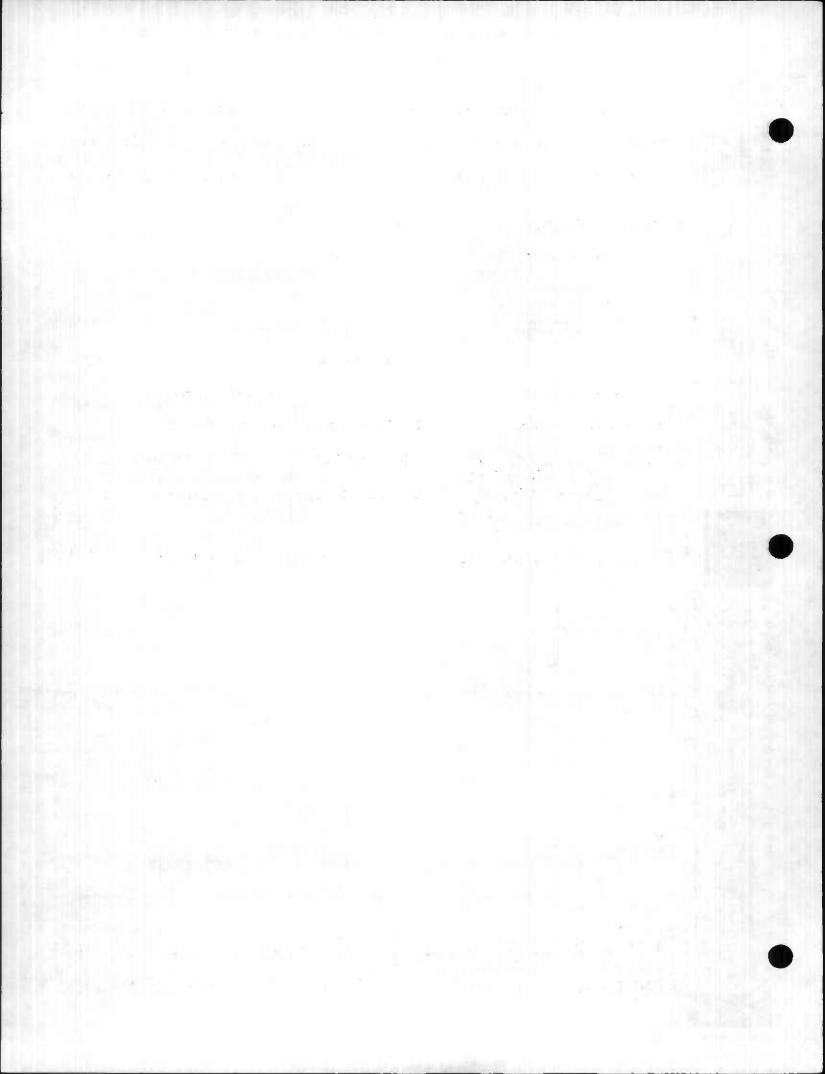
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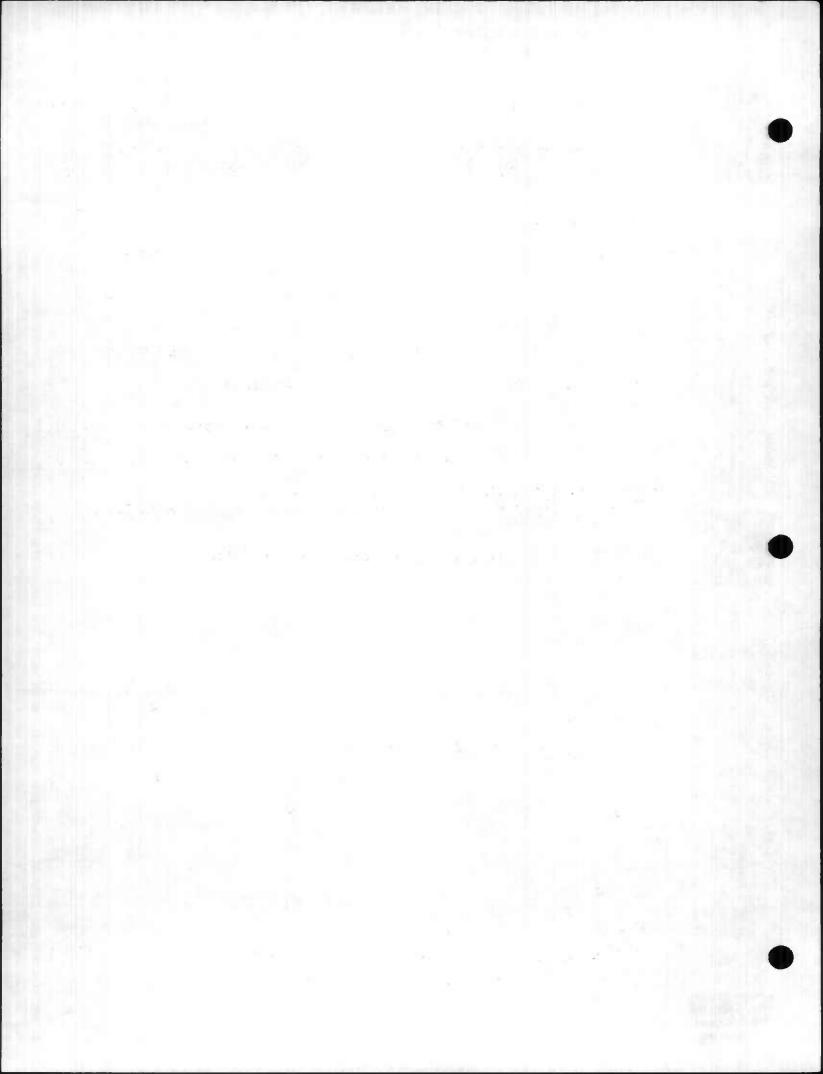
State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) Physician 4, 1999 0845 Ruth Valentine Hammell Jan. /Medical 4b, City, Town, or Location of Death 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Allegany Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. lest birthday) Birthpleca (Stete or Foreign Country) **Funeral** 1□M 2♥F Yrs. 91 Director 301-22-0601 Jan 19, 1907 Maryland Usual Residence of Decedent the Maryland 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Name 23s or 28s-f show the Medical Examiner must be notified at 1□ Yas 2□ No Directo Maryland Allegany Cumberland 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 122 ½ South Liberty St. 21502 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Datas: 14. Rece - American Indian, Black, White, etc. 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) filed within 72 hours efter 1 □ Never Married 2 □ Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Self-employed Antique Dealer Hygi 17. Fether's Neme (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: if Item 27 is marked ofth any finjury or other traumatic event page. 18. Mother's Neme (First, Middle, Malden Surnama) Be 0 Ida (Valentine) George U. Tederick 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 730 Furnace St., Ext., Cumberland, MD 21502 George H. Tederick 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20e. Method of Disposition 1KKguriel 2 ☐ Cremetion 3 ☐ Rem 1/7/98 Cumberland, MD 4 □ Ponetion 5 □ Other (Specify) Rose Hill Cemetery 22. Name end Address of Fecility Kight Funeral Home 309-311 Decatur St., Cumberland, MD 21502 23e. Pert1. Enter the disease, or complications the pauls of the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse of partitions. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in daath) · ADVANCED ALZETHMERS PEMENTIA Examiner Due to (or es e consequence of): Physician/Medical Examiner ed by the ettending physician end deteched for use as the bunel-transit death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760, Due to (or es e consequence of): 98 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. signed by to 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, þ The law requires 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24e. Was en eutopsy performed? been s certificate hes 1 Yes 2 No 1 ☐ Yes 2 PNo Physician: 25. Was case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28e. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Certification: After t 1 Netural
2 Accident 5 Pending investigation or Attending s efter deam. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide 24 hours • Funeral edicai 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as attend. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signeture And title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) cleustiano d cause of deeth (Item 23e) (Tipe Print) 30. Neme end eddress of person who complet This +RREPA ROBUSTIANO JR.MD. MEMORIAL HOSV. CUMB., MD 21502 31. Dete filed (Month, Dey Year) JAN 0 6 1999 32. Régistrer's Signature State Registrar



State of Maryland / Department of Health and Mental Hygiene 9

						Cen	incate of	or L	Jeath	4	Reg. No).			
Physicia	an	1. Decedent'a Neme (First, Middle	* ***							2. Date of Do Month	Da	у	Year	3. Time	
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Examin	er	4a Facility Name (If not institution	n, give street and nu	umber)				48	o. City, Town, or L	_ocation of Dee	th 4c	. County	of Death		
		ALLEGANY CO				1	If Under 1 Y	oor	CUMBERL If Under 24 Hrs.	AND		ALLE			
Funeral		5. Sociel Security Number 212-12-8336	6. Sex 1 ☐ M 2 ☐ F	7. Age (Ir	yrs. last birt	rs.		ays	Hours Min.	8. Date of Bi (Month, D APRIL	ay, Year)	020	Coun	try)	or Foreign
Director		Usual Residence of Decedent	AA	/	0					AFKIL	20 1	920	MAK	YLAND	
and land		10a. State 10b. County		10	c. City, Towr	or Loc	ation						11	0d. Inside (City Limits
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rott	Director	10e. Street and Number					10f. Zip Coo	de			10g. Cit	tizen of W	/hat Coun	try?	
3 with	0	33 ARCH STREET					2	150)2			U.S.	Α.		
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2 8 2 7 5		20e. Method of Disposition 1 ☐ Buriai 2 ☐ Cremetion	3 Removel from	State	cemeter	y, crem	atory or other	place		Date			City or To		
Pag Iment Isant: I		4 Donetion 5 Other (S			SUNSET	1			1	1999	CUMB	ERLAI	ND MA	RYLAI	ND
permit. Pag Department Important: I any Injury o		21. Sin Julie of Funeral Service	Licensee				Name and A			DAT HOM	17				
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/Medical Examiner		Immediate Cause (Final disease or condition	a 50	UAM	DUS	CE	74	C	A, LI	ING			1	11 N	105.
LAGITITICI	_	resulting in death)	7	Due	to (or as e	onsequ	ence of):						1		
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the the scheet	1ys	Part II. Other significant condition	ons contributing to d	Jeath but no	ot resulting in	tne un	denying ceus	e give	n in Pert I.						of death?
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or Attending Physician: The law requires that the death effect death. Director: After this certificate has been signed by the etter bin by the funeral director, page 2 should be deteched for a	Completed by Physicia	P. MELLIT								24a. Wa	s an auto	psy	24b. We	ere autops	y findings
Should should	ete	CORDUA	NY H	EAR	-T	015	SEAJ	E		per	formed?		CO	elieble prio mpletion of death?	cause
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Phy Phy C	7: To	27. Manner of Death	28e. Dete	Inpatient of Injury	2 ER/Ou	ime of		Injury Work		lome 5 Res				γ)	
After fune	tion	1 Netural 5 Pendir 2 Accident investi	9 .	nth, Dey Ye		njury	М		? res 2 □ No						
deat deat ctor: y the	flca	3 Suicide 6 Could	not be	e of Injury -	At home, fa	rm, stre	et, factory, of			28f. Location	(Street a	nd Numbe	er or Rura	il Route Nu	ımber,
offer of in b	Certification:	4 Homicide	build	ding, etc. (S	Specify)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To	own, Stet	e)			
spita sours neral		29a. Certifier Cartifyin	g Physician: To th	e best of m	y knowledge	death	occurred et th	ne tim	e, dete and place	, end due to the	e ceuse(s	end me	nner as s	tated.	
Ho 124 h Fur letely	edicai	(Check only 2 Medical one)	Examiner: On the t	basis of exe	mination end	l/or Inve	estigation, in a	my op	inion, deeth occu	rred at the time	, dete en	d pieca, e	and due to	the cause	o(s)
To the Hospital or Attending Physician: The live within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifie			1		29c. Li	cense	number		29d. Da	ate signed	Month,	Day, Year)	
		I that I	- 1	/	1	^	0.	- 1	4865		IAK) 2		1999	9
6	- 1	30. Name and address of person	who completed car	ise of death	(Item 23a) (Type =	Print)		1003		NAI	-	1	161	1
9	\	ROBUSTIAL		1	BADO	CM.	1	11	2 . AA	MEMO!	RIAL	HOST	PITAT	CUMF	BERLAN
Stat	te	31. Date filed (Month, Day, Year)		Registrer's	Signature			41	101	2					
Registra	_	JAN 0 4	1999	1	read	13	A.		e ,						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 17:29 YRONE HICKSON /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner PG CA SUERLY . 9. HOSPITM If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 5. Social Sacurity Number 6 Sax 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Months Hours 28 Yrs. 1970 Wash., Director 19 579-84-1228 the Maryland 10a State 10c. City, Town or Location 10d Inside Clty Limits 10b County "natural", or items 23s or 28s-f show ocical Examinar must be notified at 1 X Yas 2 □ No Prince George's Seat Pleasant Directo Md. 10g. Citizan of What Country? 10e. Street end Number 10f. Zip Coda with 20743 United States 6202 Baltic Street Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ntt: if item 27 is marked other than "natural", or items 23. 12. Was Decedant Evar in U.S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian 11 Marital Status Armed Forcas?

1 Yas 2 No
If Yas, Giva
Yaar or Datas: Black, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas P☐ No Specify: Specify: by 3 Widowed 4 Divorced Black Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than "natur treumatic event, tre Medical 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Entertainment 12th Entertainer 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fether's Nama (First, Middle, Last) Be John H. Hickson Alice M. Flowers 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 6202 Baltic St. Seat Pleasant, Md 20743 Mother Alice M. Hickson / or other 1 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or once. Harmony Memorial Pk.1-14-99 Landover, Md. 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signature of Funaral Sarvice Licer 22. Nama and Addrass of Facility Capitol Mortuary, Inc. 20002 1425 Maryland Ave., NE Wash., DC Part 1. Enter the disaese or complications that caused the death Definition anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. If the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Batween Onsat and Death **Physician** SEPSIS E SEPTIC SHOCK. /Medical Immadiete Ceuse (Final disaasa or condition rasulting in daath) Examiner Examinet The law requires that the death certificete be executed physician and the burial-transit Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in daath) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of): signed by the all Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco uas contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy page 2 s certificate 1 ☐ Yas 2 XNo 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: Be 25. Was casa rafarred to medical axaminar? 26. Place of Daeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No ↑ Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Dascribe how injury occurred 28b. Time of 28a. Data of Injury (Month, Dev Year) 28c. Injury at Work? Certification: After 5 Panding invastigation 1 Matural after death. Director: Aft 1 Yas 2 No 2 Accidant 6 Could not ba determined 3 Sulcida Location (Streat end Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Specify) completely filled in by 4 Homicida To the Hospital of within 24 hours all To the Funerel D Tertifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated. edicai 29e. Certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 7685

State Registrar 31. Data filed (Month, Day, Year)

JAN 13 1999

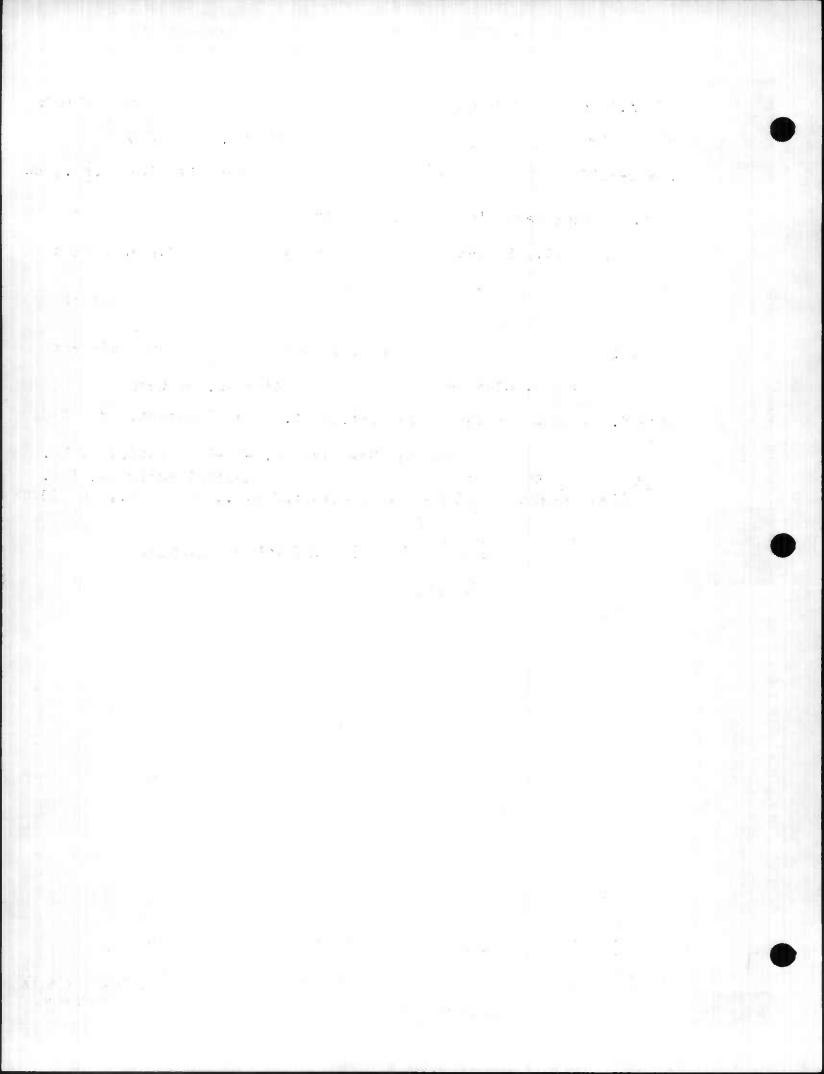
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L V S HW ANI
32. Registrar's Signatura

30. Nama and add/ass of person who completed cause of deeth (Item 23e) (Type, Print)

DEPT CRITICAL CARE

PG HOSPITAL CTR CHEVERY MD.



If Under 1 Year

Deys

Months

7. Age (In yrs. last birthday)

10c. City, Town or Location

HYATTSVILLE

84

Birthplece (State or Foreign Country)

10d. Inside City Limits

TYPES 2 No

S.C.

4c. County of Death

MONTGOMERY

TAKOMA PARK

8. Date of Birth (Month, Day, Year)

JUNE 5 1914

If Under 24 Hrs.

Physician /Medical Examiner

JAMES

5. Social Security Number

MD.

579 12 4734

Usuel Residence of Decedent

10b. County

P.G.

WASHINGTON ADVENTIST HOSPITAL

M 20 F

Funeral Director

28a-f Name 23a or permit. Pages 1 and 2 should be fill.
Department of Health and Mental He
Important. If Item 27 is marked oth any injury or other traumetic event

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Box 68760, Records, P.O. Division of Vital or Attending Physician:

To the Hospital or Atlandir within 24 hours after deeth. To the Funeral Director; A'

Director 10e Street and Number 10f Zin Code 10a. Citizen of What Country? 6500 RIGGS ROAD 20783 USA Funeral 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) PVT. College (1-4or 5+) CONTRACTOR 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be NOT STATED NOT STATED 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) EDITH GREEN/DAUGHTER 1417 DOWNING ST., N.E. WASH. D.C. 20018 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State FT. LINCOLN CEM. 1/11/99 4 ☐ Donetion 5 ☐ Other (Specify) BRENTWOOD, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WATSON F. H.INC. 23a. Pert1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death ARTERIOSCIENOSE CANDIDIASCULAR DIJEASE Immediete Cause (Final years disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? GATTRIC CAREINOMA COLON CAREINOMA 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? CARGINOID TOMOR, ILEUM RESPIRATORY FAILURE 1 Yes 200 No 1 Yes 2 No 25. Wes case referred to medical examiner?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. Medical 29e. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 201852 JANUARY 7,1999

State Registrar

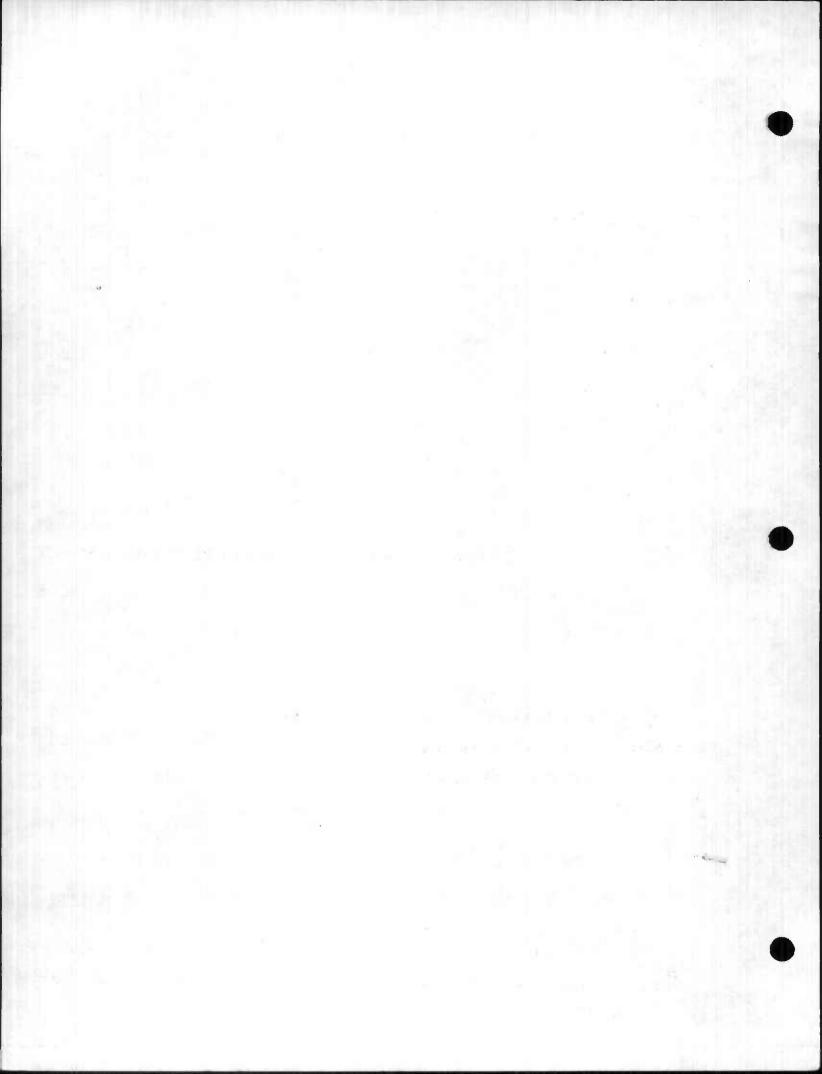
31. Date filed (Month, Dey, Year)

JAN 13

DHMH 16 Rev 6/95

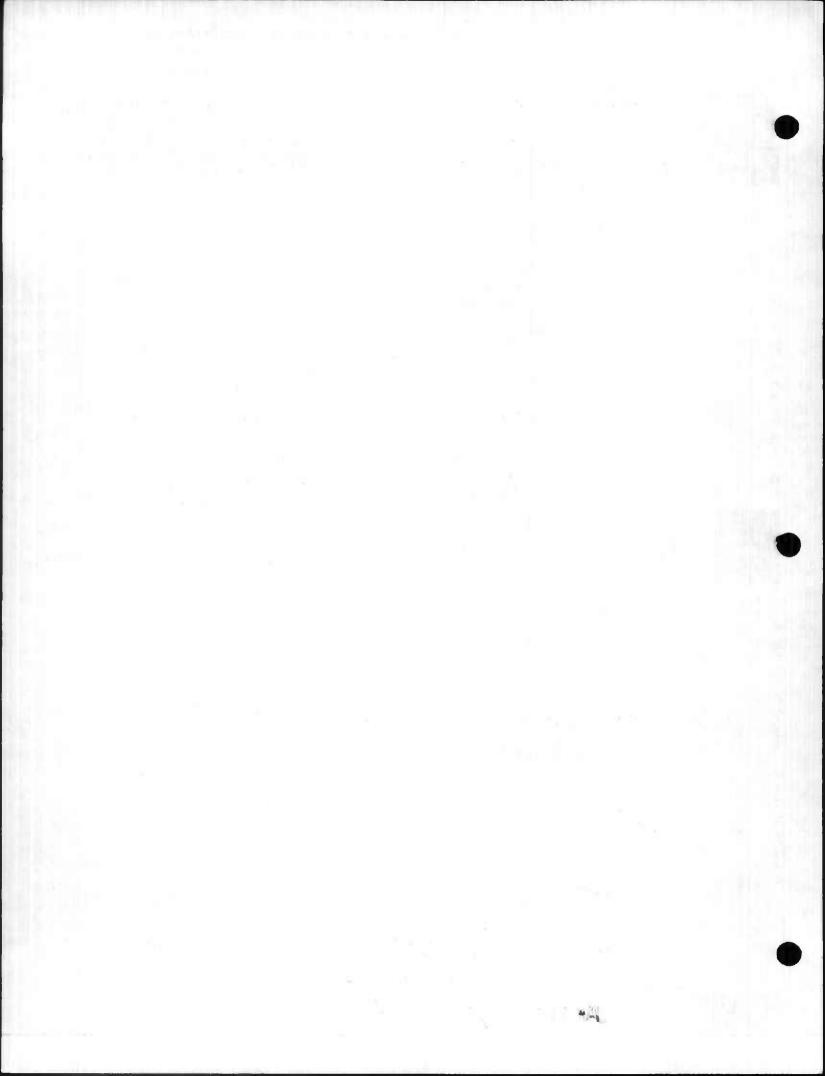
32. Registrar's Signeture

30. Name and address of person who completed cause of deeth (term 23a) (Type, Print)
PAUL A. DEVORE, MD 4203 QUEENSBURY Rd HYATTSVILLE MD 2078)



State of Maryland / Department of Health and Mental Hygiene C

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death **Physician** Month Warren Kenneth HARRISON 03, 1999 3:45 pmJanuary /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daeth 4c. County of Death Examiner Frederick Health Care Center Frederick Frederick Hours Min. May 15, 1921 5. Social Security Number If Undar 1 Yaar Birthplace (State or Foreign Country)
 Maryland 7. Aga (In yrs. last birthday) **Funeral** 18 M 2□ F Months Days 220-10-5219 Yrs. Director Usual Rasidance of Dacedant with the Marylend 10a State 10b. County 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Modical Examiner name be notified at 10c. City, Town or Location 10d. Insida City Limits Director 1 TYas 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? permit. Peges 1 end 2 should be filed within 72 hours after deeth with Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or is any injury or other traumatic event, tra Madrial Emericana 2000. 212 Linden Avenue 21703 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forcas? 1 ⊠ Yas 2 □ NOCt 42 If Yas, Giva Year or DatesJan. 46 Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black White atc 1 Naver Married 2 Married to Baltimore, Maryland 21215-0020 1 Yas 2 No by White Specify. 3 N Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Mill Worker Farmers Co-operative 17. Fethar's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Surname) Be William H. Harrison Elsie Bohn 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Peggy A. Snoots/Sister 212 Linden Avenue, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burlal 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) Mt. Olivet Cemetery Jan. 6, 1998 Frederick, MD 21. Signature of Funaral Service Licensee 22. Name and Addrass of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part 1. Entar the disaasa, or complications that ceused the deeth. Do not antar the mode of dying, such es cardiac or respiratory errest, shock, or heer failure. List only one cause on each line. **Physician** /Medical Immadiate Ceusa (Final disaase or condition rasulting in daath) reas **Examiner** Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequantially list conditions, if any, leading to immediata ceuse. Entar Underlying Causa (Disaese or injury that initiated events rasulting In deeth) Last Dua to (or as a consequence of): Box 68760 Due to (or as e consaquanca of) for use as P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the should be detached 23b. Did tobacco usa contribute to the causa of death? 10 Yes 2 No 3 Probably 4 Unknown Records, Completed by ypertension 24b. Wara autopsy findings available prior to completion of cause of daath? 24e. Wes an autopsy performed? page 2 1 ☐ Yas 2 1 NO 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physicien: Be 25. Was cese refarred to medicel axaminar? 26. Placa of Death (Check only one) Hospitel: 2 20 No Other: All Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Menne of Death 28a. Deta of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Panding Invastigation death. 1 ☐ Yas 2 ☐ No 2 Accident efter death 3 ☐ Sulcida 6 Could not be daterminad In by t 28a. Plece of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicida within 24 hours of To the Funeral I 29a. Certifiar 1 Certifying Phyafcfan: To the best of my knowladga, daath occurred at the tima, data and plece, and dua to tha causa(s) and mannar as stated. Medicai completely Madical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, date end piece, and due to the ceusa(s) and mannar stated. (Check only one) 2 29b. Signeture end tale of certifie 29c. License number 29d. Data signed (Month, Day, Year) D35183 January 04, 1999 30. Name end address of parson who complated oddsa of deeth (Itam 23a) (Type, Print) Ali J. Afrookteh, M.D., 300 West Ninth Street, Frederick, Maryland 21701 31. Data filed (Month, Day, Year) 32. Registra s Signatura State Registrar



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

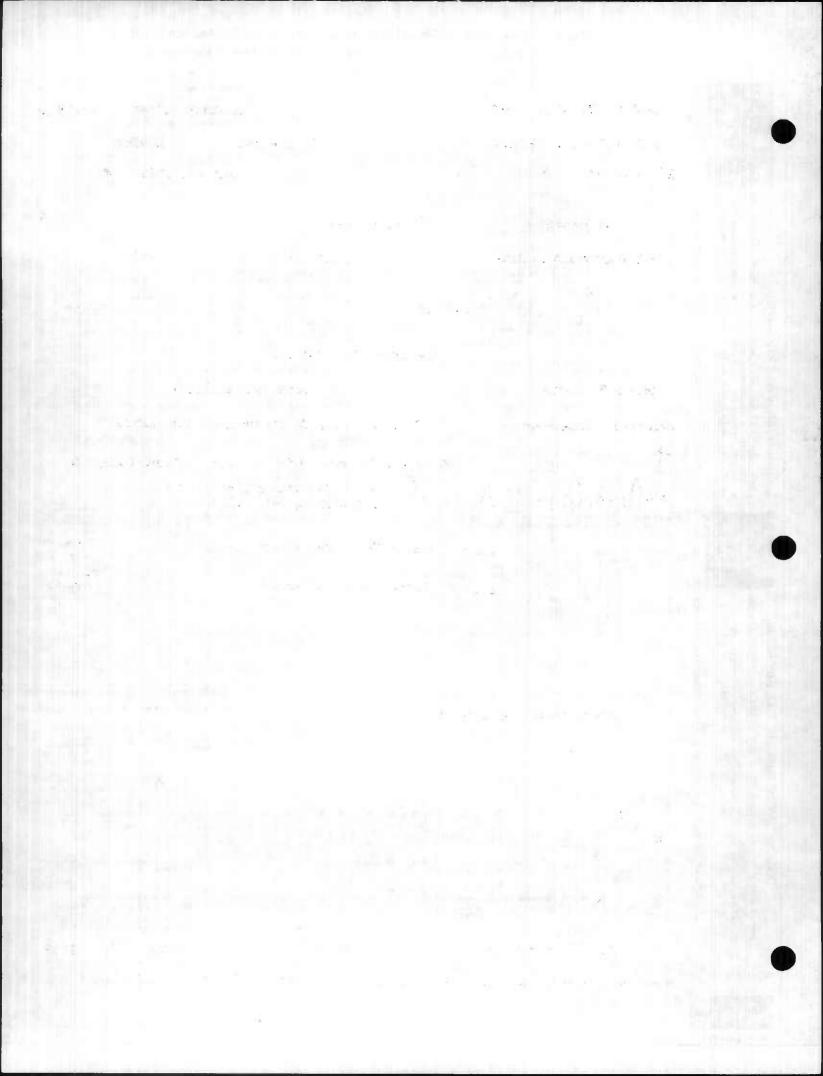
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6	ta Facility Neme (/						4b. City, To		cation of Deatl			000 111
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4.80	5. Social Security N		Sex 1 ☑ M 2 □ F	7. Age (In yrs.		If Under 1 Ye Months Day		Min.	8. Date of Bir (Month, Da	y, Year)	9. Birthp	lace (Stete or Fo
	213-40-6 Usual Residence of		TOM ECOT	56	Yrs.				DEC. 2	8, 1942	MAR	YLAND
	10a. State	10b. County		10c. Ci	ty, Town or Loca	tion					10	0d. Inside City Li
	MARYLAND	FREDER	TCK	FD	EDERICK							1 ☐ Yes 2 🔀
	10e. Street and Nur			FK	PDEKTCK	10f. Zip Code	9			10g. Citizen of W	hat Coun	try?
	5730 MAI	NS LANE				21704				USA		
_	11. Marital Status	НО ДИМЕ	12. Wes Dece	edent Ever in U	J,S. 13. We	s Decedent o	t of Hispanic Ori uban, Mexican	gin? (Spe	cify Yes or No	- 14. Race	- Americ	an Indian,
	1 Never Mem	ed 2 Married 4 Divorced	1 1 Yes		10	Yes 2 N		, 1 0010 1	iouri, oto.y	Specify:		
	(Soec	15. Decedent's I	Education		16a. Deceder	nd of work do	ne durina mos	t of workir	00	16b. Kind of Bus	siness/Ind	lustry
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	12	(Eiret Middle 1	1		BOILER	PLANT	OPERA'		(Class Adida)			ERNMENT
	17. Father's Name									Maiden Sumame		IF 77 7 7 7
Н	JOHN S	SAMUEL eme/Beletionship	HANN (Tuna Print)		10h Mailine	Address /St		HERIN		ELIZABET er, City or Town, S		KRISE
L											<i>310</i> 118, ∠1β	0000)
_	NANCY L. 20a. Method of Disp		(WIFE)	20b. l	Place of Disposit	ion (Name of		KEDEI	Date	ID 21704 20c. Location - (City or To	wn, Stete
	1 Surial 2		Removel from	21616	TABOR			11		ROCKY RI		
-	21. Signeture of Fu			HII.			dress of Facilit		1/99	KUCKI KI	LDGE,	MARILA
	1	/4/							SON FUN	ERAL HON	MES,	P.A.
H	23a. Part1. Enter B shock, or hea	perdisease or co	molications that c	aused the dea	th Do not enter	E. MA	IN ST.	. THU	JRMONT,	MD 2178	38	Approximete
l	resulting in death) Sequentially list coil if any, leading to im	nditions,	b	Due to (or es e conseque	ince of):					1	
	Sequentially list co if any, leading to im- cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	rlying injury _ast	c	Due to (c	or as a conseque	nce of):						
F	Part II. Other signifi	icant conditions	contributing to de	ath but not res	sulting in the unde	erlying cause	given in Pert I		23b. Did	lobacco use con	tribute 10	the cause of d
									10	Yes 2 No	3 Prot	pebly 4□Uni
									24a. Wes	an autopsy rmed?	ava	ore autopsy find allable prior to appletion of caus death?
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- 2	25. Was case refer	ed to medical					26. Place	of Deeth	(Check only o			
- 2	25. Was case referi examiner? 1 [X] Yes 2 □		Hospitel:	npatient 2	ER/Outpatient	3⊠ DOA	Other			dence 6 Othe	r (Specif)	1)
	examiner? 1 [X] Yes 2 □ 27. Manner of Death	No	1 4	npatient 2 Dof Injury	ER/Outpatient 28b. Time of Injury	28c. Ir	Other: 4 Nu njury at Vork?	irsing Hon	ne 5 Resi	dence 6 Othe	ed	
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 3 Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** CLAUDE WILLARD JONES JANUARY 3.1999 10:25 AM /Medical 4c. County of Death 4e Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death Examiner SACRED HEART HOSPITAL ALLEGANY CUMBERLAND Birthplaca (Stata or Foraign Country)
 MD If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours XOM 20F Yrs. 212-24-2219 69 Jan 28, **Director** Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 🏖 ☐ No Director Corriganville Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with r than "naturel", or items 23s or the Wedical Examiner must be a USA 11218 Poorbaugh Avenue 21524 deeth . Funerai Permit. Pages 1 and 2 should be filed within 72 hours after deen Department of Health and Mental Hygiane. Important: If them 27 is marked other than any injury or other transmission. 12. Was Decedent Ever in U,S. Armed Forcas? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status NO Yes 2 No If Yes, Give Year or Dates: 1947-50 1 Never Married 2 Married 1 Yas No þ 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Glass Cutter PPG 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Thomas B. Jones Anna Mae (Miller) 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 147; Corriganville, MD 21524 Jeanne L. Jones--wife 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans Cem 4 ☐ Donetion 5 ☐ Other (Specify) 01/06 Flintstone, MD 22. Nama and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the deam. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician TWELVE LEFT CEREBRAL INFARCTION Immediate Cause (Final disease or condition resulting in deeth) /Medical HOURS Examiner Due to (or es a consequenca of): TWELVE EMBOLUS Examiner HOURS LEFT CENEBRAL and-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be axecu -lainq Box 68760. physician the buria Physician/Medicai Due to (or as a consequence of): Se use 23b. Did tobacco use contribute to the cause of death? ed by the datached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown MULTIPLE SCLENOSIS Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed DIABUTES peen s certificate has b 1 Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) To Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of Injury Certification: 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ò 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as steted. To the Hosp within 24 hor To the Fune completely fi edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated. (Check only one) 29b. Signatura and title of certifier 29c, License number 29d. Data signed (Month, Day, Year) lloen mo D33417 **JANUARY** 1999 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 21502 1068 NATIONAL HIGHWAY LAVALE, MARTLAND AMES R. MOEN, M.D. 31. Dete filed (Month, Day, Year) 32. Registrar's Signature JAN 0 5 1999 Registrar

DHMH 16 Ray 6/95



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State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** 8, 1999 ROBERT KAPLOW JAN. 11:35 AM L. /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X0 M 2□ F Months Days Hours 76 Yrs. Director 083-12-6740 JUNE 3,1922 NEW YORK Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic avent, the Medical Examinal must be notified at 1 XYes 2 □ No Director MONTGOMERY SILVER SPRING MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 CLAYBROOK DR. 20902 U.S.A. Funeral death 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 end 2 should be filed within 72 hours after can of Health and Mental thygiene.
nt: if item 27 is marked other than "natural", or ites
iny or other traumatic avent, its Medical Examina. 1 Never Merried 2K Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: À Year or Dates: WWII 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4 PHOTOGRAPHIC ENGINEER FED. GOV'T. 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JACOB** KAPLOW **ESTHER** KROLL 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET R. KAPLOW/WIFE SAME ITEM #10 AS 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CHAMBERS CREMATORY 1/11/99 RIVERDALE, MD. 21. Signature of Funeral Service Lice 22. Name end Address of Facility SILVER SPRING, MD. M00091 CHAMBERS FUNERAL HOMES, P.A. 20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication and caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cardiac on each line. **Physician** /Medical Immediate Cause (Final HEPATIC FAILURE 2 DAYS diseese or condition resulting in death) Examiner Due to (or es e consequença of): Examiner 1 MONTH ADENOCARCINOMA-PRIMARY SITE UNKNOWN physicien end s the buriel-trans Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760 certificate be Physician/Medical Due to (or as e consequence of): 80 attending p the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by 1 Tes 2 No 3 Probably 4 to Unknown by 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy Completed peen performed? page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 2 Months and Service
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2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Dete signed (Month, Day, Year) 29b. Signeture end title of cartifier 11+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D00143 JAN. 8, 1999 20910

State Registrar HUBERT

31. Date filed (Month, Day, Year)

J.

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ALPERT, M.D. 8630 FENTON ST., #230, SILVER SPRING, MD.

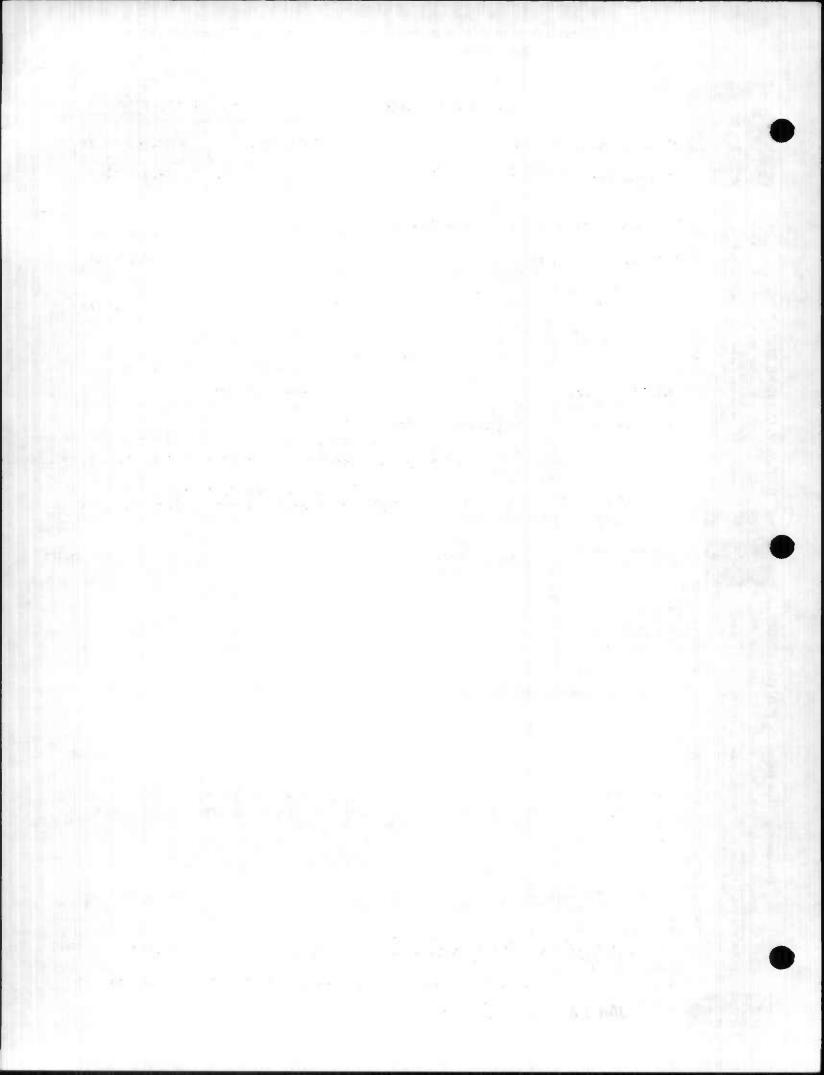
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State of Maryland / Department of Health and Mental Hygiene o

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State of Maryland / Department of Health and Mental Hygiene

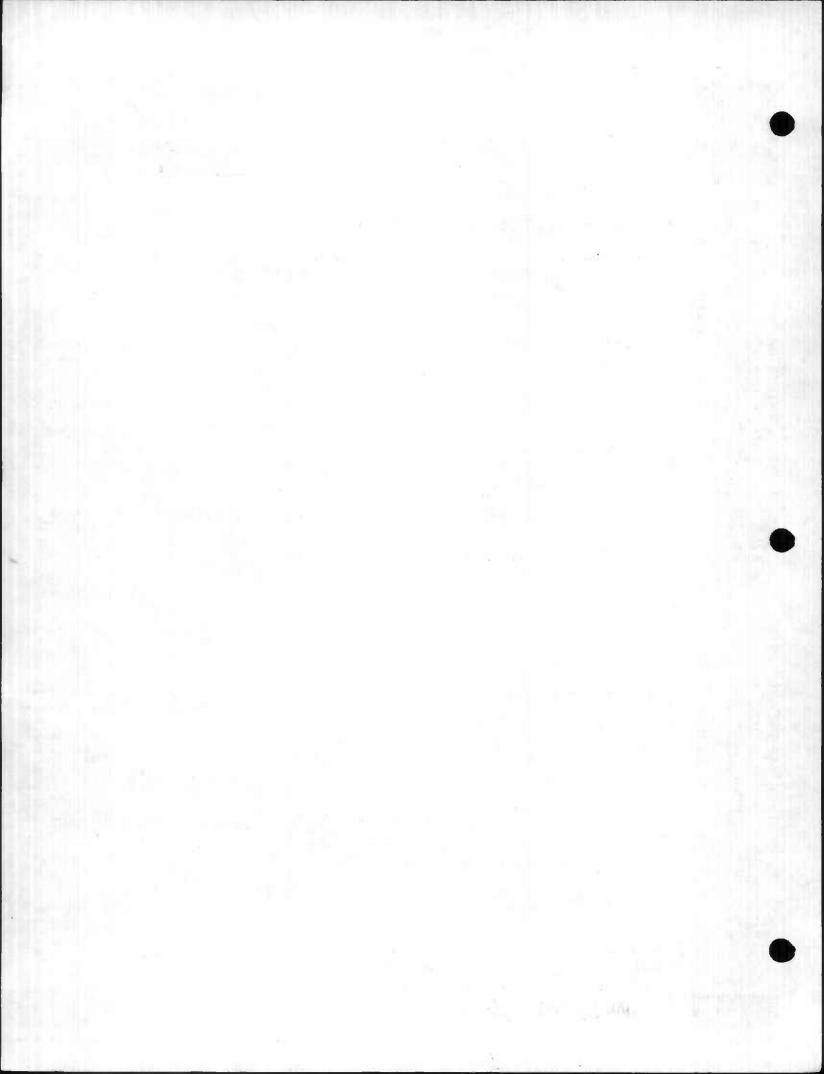
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Funeral Director		219-10-2041	. Sax 7. Ag 1 ☑ M 2 ☐ F	a (In yrs. last	Yrs. Month	dar 1 Yaar ns Days	If Undar 24 Hrs Hours Min.	(Month, Da	th y, Year)	9. Birthplaca (Si Country)	ata or Fon
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28	Director	10e. Street and Number				Zip Coda			10g. Citizan of V	What Country?	
380		5401 Westbard	Avenue #31	3		20816	5			States	
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h and Mental Hygiene. F is marked other than " traumatic event, tra Mer	0	John A. Kirk,	Jr.				Genevie	eve Umst	ead		
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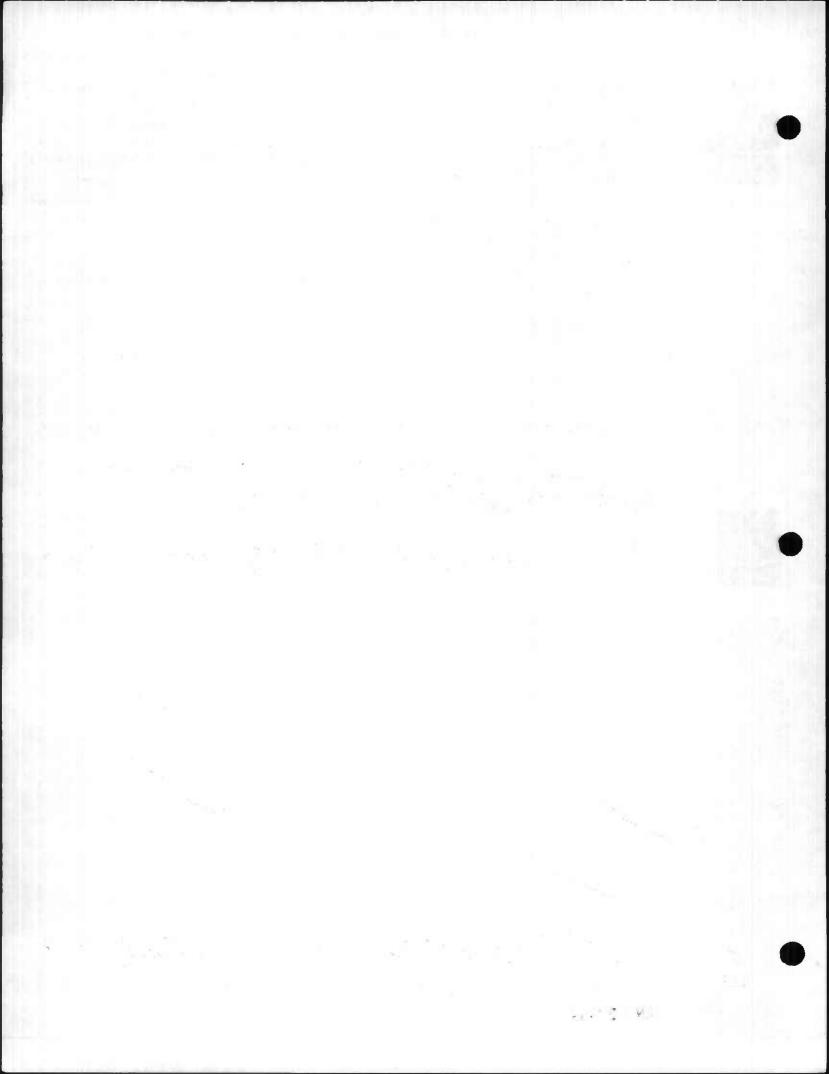
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Young	Kyun K	o					January			6:40 AM
4a Fecility Name (#			mber)			4b. City, Town, or	Location of Deet			
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5. Social Security No				. last birthday)	If Under 1 Year	If Under 24 Hr	8. Dete of Bir			ece (State or Foreig
213-13-4		15€M 2□ F	67	Yrs.	Months Deys	Hours Mir	Aug 2	1931	Kore	a 2
Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Loc	ation				10	Od. Inside City Limits
MD	Prince	Georges		Greenbe	1to					1 ☐ Yes 2 ☒ No
10e. Street and Nun					10f. Zip Code			10g. Citizen of V	Vhat Count	iry?
9100 Spr	inghill	Lane, A	pt. 303	3	207	70		Kor	ea	
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	15. Decedent's		0100.	16a. Decede	ent's Usual Occup	pation		16b. Kind of Bu	usiness/Indi	ustry
		grade completed) College (1	45-1	(Give k	ind of work done O NOT use retire	during most of world)	orking	Video A		
Elementary/Secon		College (1	1-40r 3+)	Smal1	Business	s Owner			Enter	ctainment
17. Father's Name ((First, Middle, L	ast)				18. Mother's Na	me (First, Middle	, Meiden Sumem	10)	
Byung Se	ung Ko					Yuh Je	on Shim			
19a. Informant'a Na	me/Reletionsh	ip (Type, Print)		19b. Meiling	Address (Street			er, City or Town,	Stete, Zip	Code) 20770
Son Ye K	oh	(w	ife)	9100 S	pringhi	ll Lane.	Apt. 30:	3. Green	belt.	MD
20a. Method of Disp	position		20b.	Plece of Dispos	ition (Neme of etory or other ple	ical .	Dete	20c. Location -		
1 ☑ Burial 2 ☐ 4 ☐ Donation		3 □Removel from :	Siele				1/11/99	Silver	Sant	no MD
21. Signature et Fur			Ga				rancis J			
D & 1	. /	Vacala	n	Но	me, Inc.	. 500 U	niversit	y Blvd.	West	
22a Borts Enter th	u p	pcere	y award the doc			ring, MD	20901			Approvimete
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	it lalidie. List o	only one cause on e	ech line.	ath. Do not enter	r the mode of dyi	ng, such es cardi	ac or respiretory a	rrest,		Approximete Interval Between Onset and Death
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Immediate Cause (I disease or condition resulting in death)	Final	only one cause on e	inoma c	of the 1	ungs wi		ac or respiretory a			Interval Between
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State of Maryland / Department of Health and Mental Hygiene

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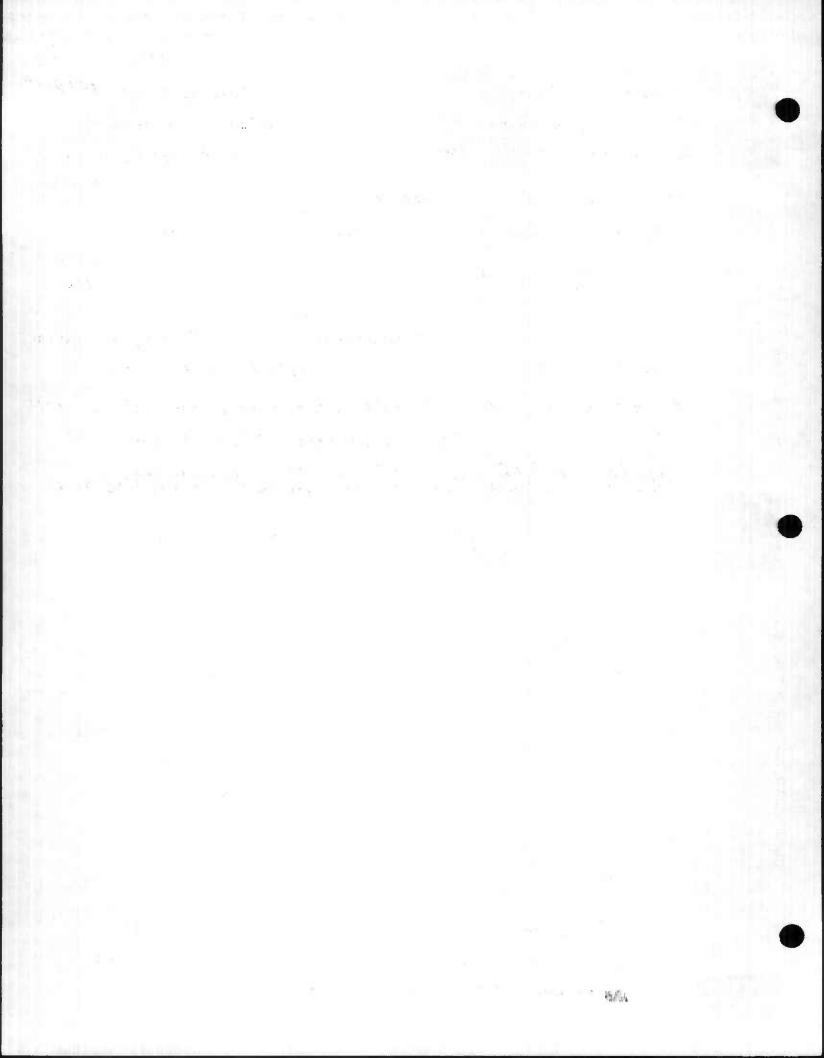


State of Maryland / Department of Health and Mental Hygiene

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				1882	801 To	rpe, Print) LI HOUSE A	FRE. FRE	DERICK	MD 217	701	
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State of Maryland / Department of Health and Mental Hygiene 9 9 0 | 5 9 7

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17 February Name First, Middle, Last) 18. Mother's Name (First, Middle, Last) 19. Mother's Name (First, Mi	A 2" A . P	S	8		13	lectr	icia	n		Washin	gton	Termino
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The suppose of the state of the	0 0 0	SICI	Part II. Other significant conditions con	ntributing to deeth but not	resulting In th	e underlying	g cause giv	en in Part I.	23b. Dld	tobacco use cor	tribute to the	he cause of death
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30. Name and address of person who completed cause of death (item 23e) (Type, Print) Kusan BARAKAT 310 w 9th 5 feet Cabrielle MD 21701	Hospit 24 houn Funers		(Check only 2 Medical Exami	ner: On the basis of exam	knowledge, de Inetion end/o	eath occurre	ed et the tin	ne, date and place pinion, deeth occ	a, and due to the urred et the time,	ceuse(s) and ma date and placa, a	nner as state	ed. ne cause(s)
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A LIMIN HIGH CONTROL OF THE						1	1	~ 1~~				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** ANN KNISELY JANUARY NMI 1999 12:30 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. Hours | Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1□M 2XF Months 76 Director 177-14-7284 May 11, 1922 Pennsylvania Usuel Residence of Decedent with the Merylend 10a. Stete 10c. City, Town or Location 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7400 Skyline Drive 21702 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) permit. Pages 1 and 2 should be liled within 72 hours effer c Department of Heelth and Mental hygiene. Important: If item 27 Ie marked other than "naturel", or item eny injury or other treumatic event, the Medical Examines once. Bleck, White, etc. 1 Never Married 2 XMarried 1 Yes 2 No Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Andrew Martin Pauline Hurzd 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ralph F. Knisely (Husband) 7400 Skyline Drive, Frederick, Maryland 21702 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Locetion - City or Town, State 1 XBuriai 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Arlington National Cem. 1/12/99 Arlington, Virginia 22. Name end Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) end Failure Examiner Due to (or as a consequence of) Examiner Sepsis weeks ettending physicien end for use es the buriel-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated assets) Due to (or es e consequence of): weeks Diverticulitis Physician/Medical that initiated events resulting in death) Lest Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? should be detached the signed by 1 Yes 28 No 3 Probably 4 Unknown p 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? Completed 24e. Was en eutopsy After this certificete hes 1 ☐ Yea 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 uneral 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: s ofter death.
I Director: After to in by the funers 5 Pending investigation Natural 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end manner stated.

29c. License number MO 51610

29d. Dete signed (Month, Dey, Year)

1-3-99

Division of Vital Records, To the Hospital within 24 hours of To the Funeral I completely filled Hospital

Baltimore, Maryland 21215-0020

Box 68760

P.O.

State Registrar

29a. Certifier

(Check only one)

29b. Signature end title of certifier

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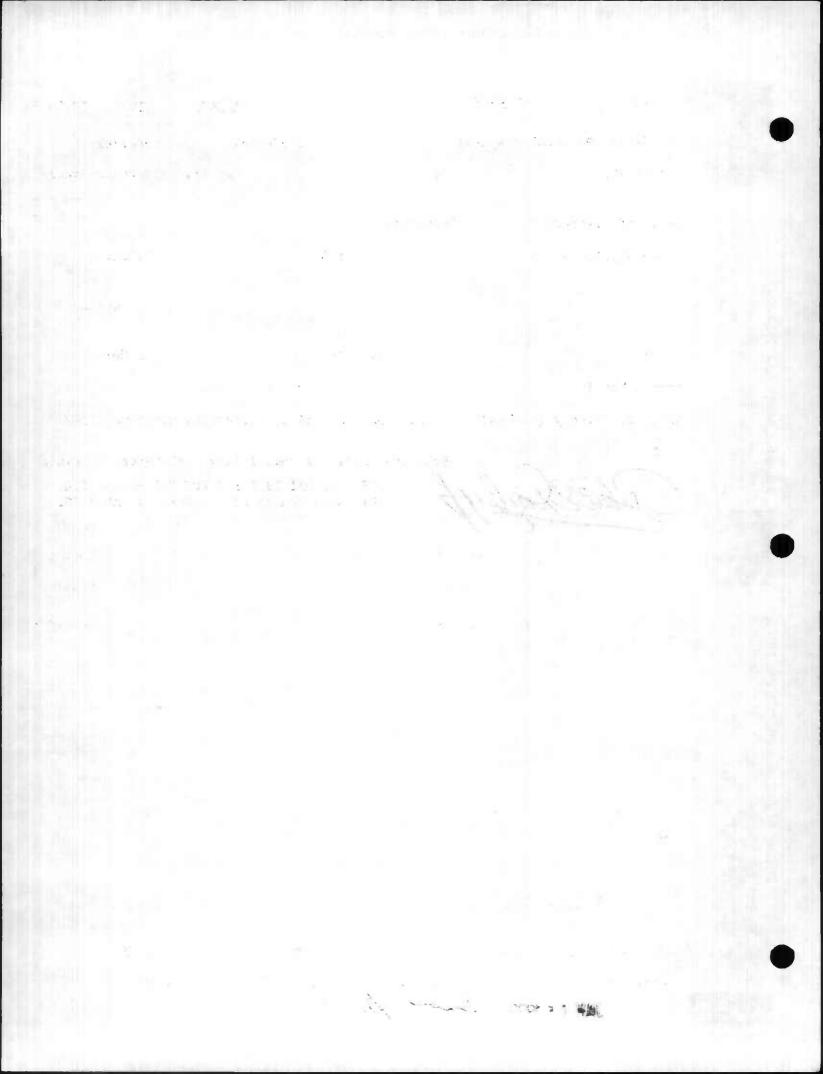
32. Registrer's Signature

204

30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print)

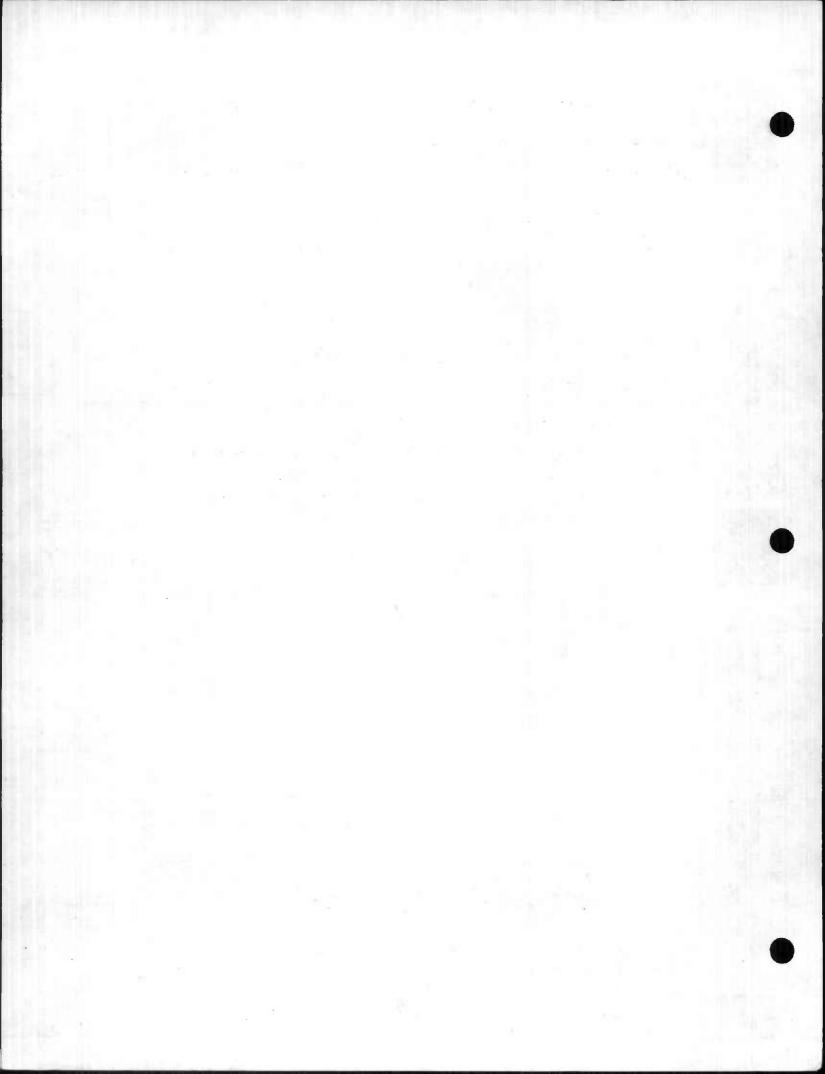
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State of Maryland / Department of Health and Mental Hygiene 9 0 | 5 9 9

				Ce	rtificate of	Death		Re	ıg. No.	0	00	
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	/Medical Examiner	4a Facility Name (If not institution, gi				4b. City, To	wn, or Loc	cation of Death	4c. County			20 20.1
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-	Funeral		Sex 7. Age (In yrs.		If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birtho	place (State	or Foreign
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	or 20	10e. Street and Number			10f. Zip Code			10	og. Citizen of	What Cour	ntry?	
	h wi	9819 Ambler 1	Lane		20	774			U.S	.A.		
	r hams 23sh recent values must	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J,S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Ori	igin? (Spe	city Yes or No-		ce - Americ		
020	E - 1	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates;		1 ☐ Yes 2 ②XNo			sican, etc.)	Specif	rck, White, by: B	lack	
21215-0020	ed within 72 hours yglene. nor than "natural", it, the Medice Completed by	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occu kind of work done DO NOT use retire	durina mos	t of working	ng	16b. Kind of B	usiness/In	dustry	
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an	A Sega									110)		
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Maryland		19a, Informant's Name/Relationship			ng Address (Stree			77.74.71.22.32.4) Code)	
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altimore,	permit. Pages 1 and 2 Department of Health of Important: if Nem 27 is eny Injury or other tra ence.	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Contents)	Removat from State	cemetery, cre-	matory or other play Funer		n. 1		99 Sur			SC
Salti	Separting mporta my Inje	21. Signature of Furniral Service Lion	1 h	An. 2	Name and Addr SNOWDE	ess of Facility N FUN	YERA	L HOME	, P.A.			771
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		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ceused the dea one cause on each line.	th. Do not en	er the mode of dy	ing, such as	cerdiac or	r respiratory arre	est,		Approxim- Interval B	etween
	Physician										Onset and	J Death
	/Medical	Immediate Cause (Finat disease or condition	. SEP	515							10	DAYS
	Examiner	resulting in death)		or as a conse	All research and a second				7,445	1		
Н	P = 0		LIVE	R	CARC	iND	MA				35	DAYS
	certificate be executed ding physician and use as the buriel-transit n/Medical Examiner	Sequentially list conditions,	Due to (or as a consec		1.40	10111					
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ō	Physical distriction of the Total distriction	27. Manner of Death	28a. Date of Injury	28b. Time o				28d. Describe ho			<i>'y)</i>	
Division	tal or Attending P is shart deeth. In Director: After the funeral in by the funeral Certification:	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury		xrk?]Yes 2 □			4.,			
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$\frac{8}{2}$	or An offerd In by	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)	reet, factory, office		-	City or Town		Del Ol Hur	ar mobile rec	moor,
	E SE O											
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	within 2. To the F complet	one)	and manner stated.									
	To To E	29b. Signature and title of certifier	10-11	A 4	29c. Licen	se number			9d. Date signe			
	3	I theda	Hh Khan	U.D	· Du	+33	23	3	TANUA	ry (01,	1499
		30. Name and address of person who	completed cause of death (Item	m 23a) (Type,	Print) A Q	= 04	AI	1 KH	AN	M·T) •	
		18111 P	RINCE PH	1410	DRIVE	SUITE	E 111	1 KHI, OLNE	Y MT	20	183	2.
	State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	dature \mathcal{J} .	Loon	1						



State

Registrar

31. Date filed (Month, Day, Year) JAN 12 1999

HARES MBENNER MD

29b. Signature and to

32. Registrar's Signature

ed cause of deeth (Item 23a) (Type, Print)

LOCKWOOD DRIVE SILVER SPE

11251

29c. License number

29d. Date signed (Month, Day, Year)

the Maryland

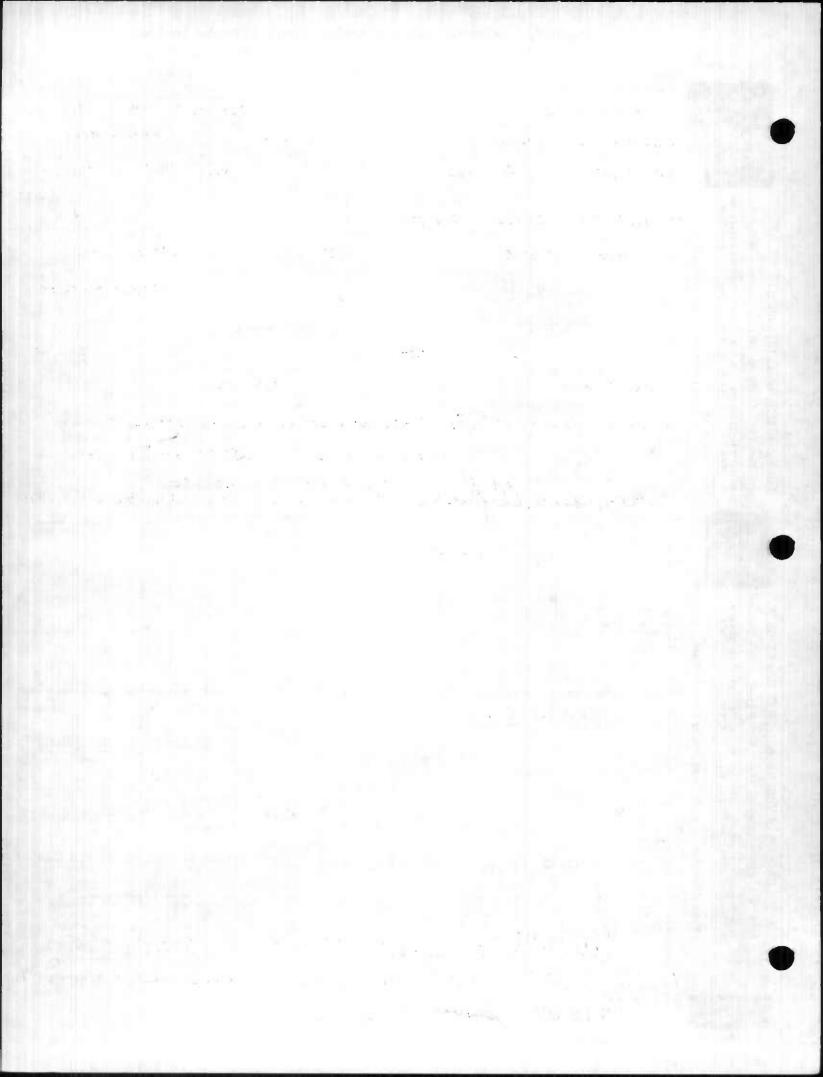
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

that the death certificate be

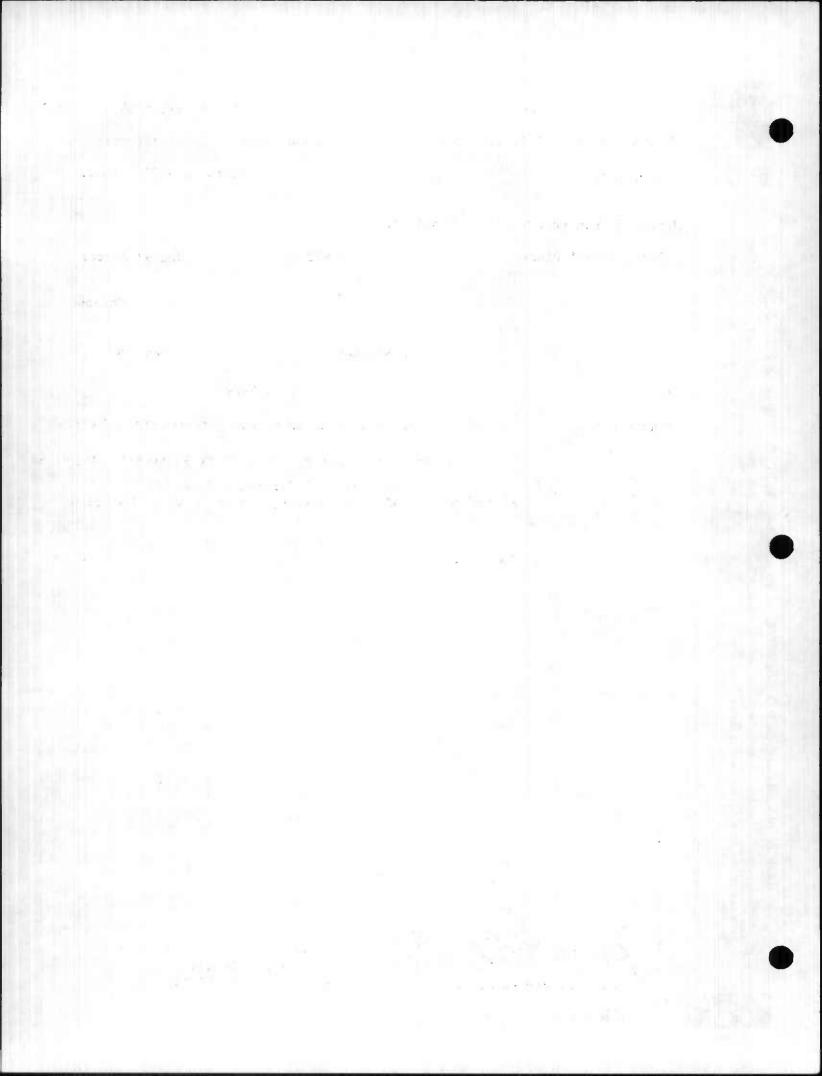
or Attending Physicien:

Hospital



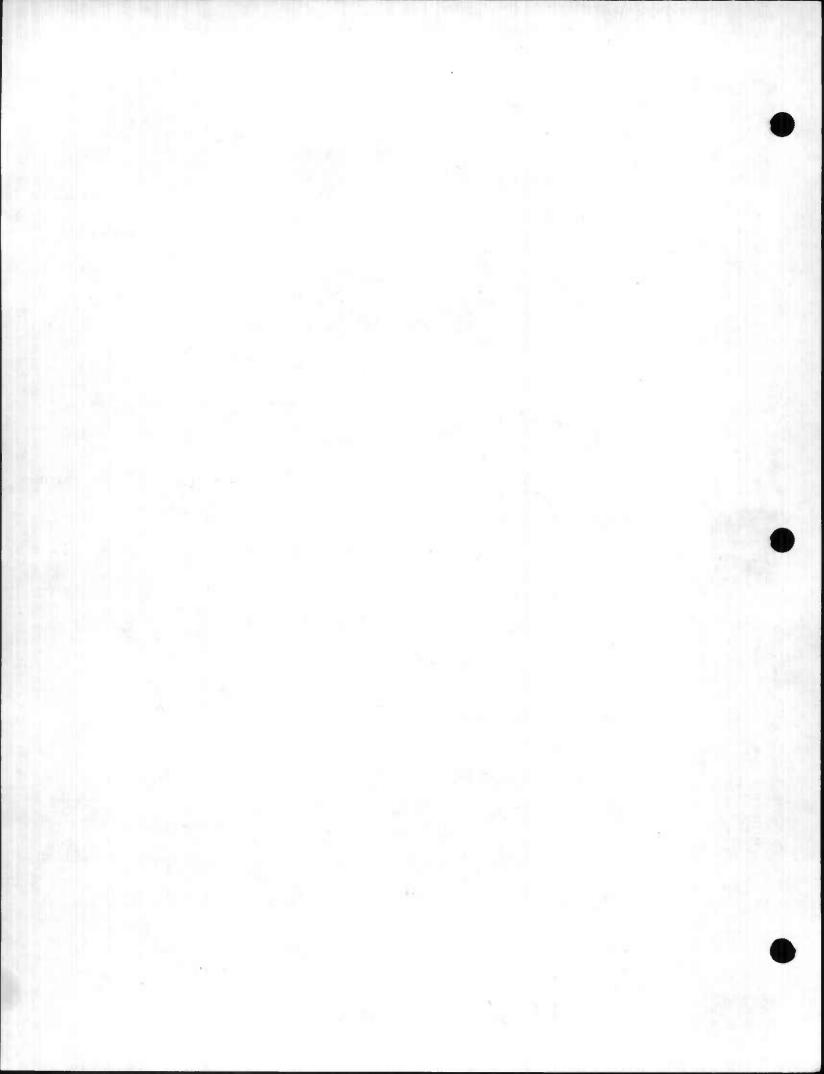
State of Maryland / Department of Health and Mental Hygiene 00 01001

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State of Maryland / Department of Health and Mental Hygiene 99 0 1602

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	Funeral Director	5. Social Security Number 228-48-236.	5 ů	®X DM 2□F	'. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min,	8. Date of Birth (Month, Day, JUNE 19	Year) , 1938	Cour	place (State ontry) GINIA	x Foreign
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<u>≥</u>	or A Directification by	4 Homicide	determined	building	g, etc. (Specify	y)	eet, iacioi	y, Unio			City or Town		01 01 11011	27 1 10 210 7 1011	
	ports ours	29e. Certifier 10	Certifying Phy	raician: To the b	est of my kno	wiedge, deatt	occurred	at the ti	ne, date an	d place.	and due to the c	ause(s) and ma	anner as s	stated.	
	To the Hospital or Attending Physicians, within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. Medical Certification: To				is of examine						ed at the time, d				s)
	within To the comp	29b. Signature and title	of certifier		^		29	c. Licens	e number	,	2	9d. Date signe	d (Month,	Day, Year)	
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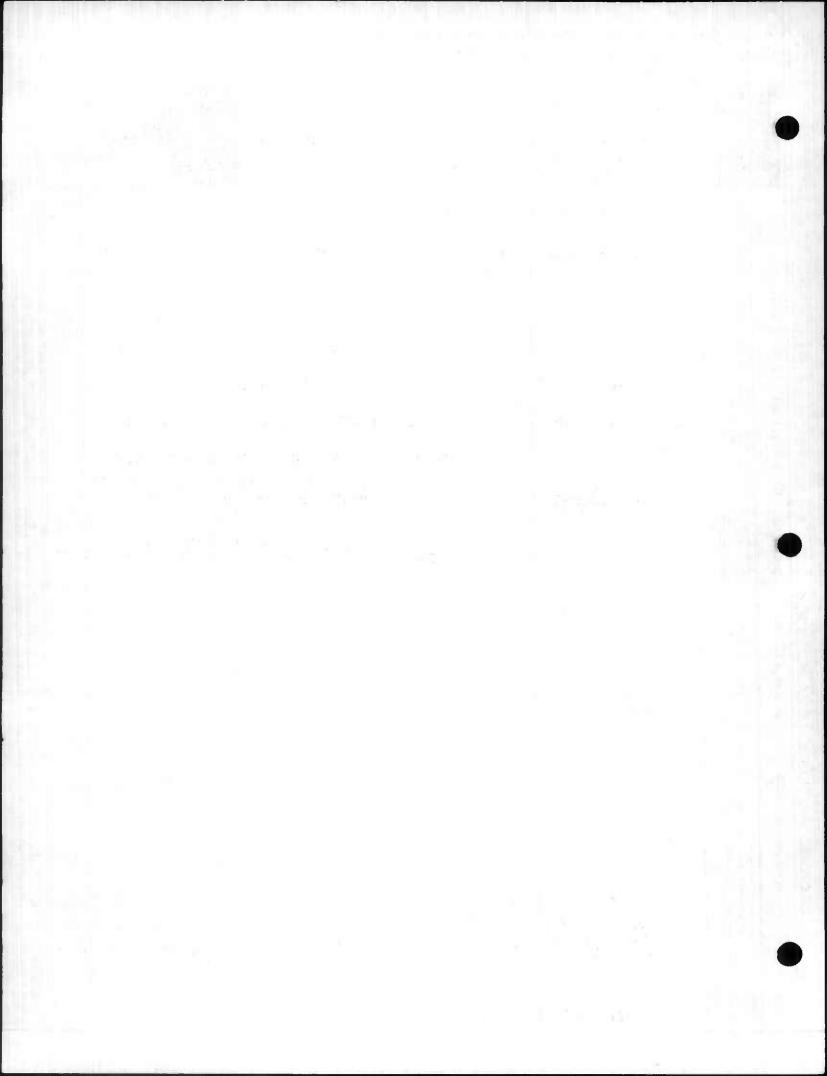
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death **Physician** JANUARY 10, 1999 LUCILLE R. LOURIE 7:45 AM /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY 5. Social Sacurity Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth Month Dey, Year) DEC 2 1910 Birthplaca (Steta or Foreign Country)
 Y 7. Aga (In yrs. last birthday) **Funerai** 1□M 2\ F 88 Yrs 109-10-2064 Director Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limita 28a-f ahow Examiner naut be notified at MD MONTGOMERY CHEVY CHASE 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? ò 8100 CONNECTICUT AVENUE 20815 UNITED STATES Itams 23s deeth Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours effer or ent of Heelth end Mental Hygiene. Int: If Item 27 is merked other than "natural", or Ital 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELIAS RADIN DORA FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Depertment of Heelth en Important: if item 27 is any injury or other trau SETH LOURIE (SON) 3205 ROLLING ROAD, CHEVY CHASE MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State KING DAVID MEM GARDENS 1/12/99 FALLS CHURCH VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC 1170 ROCKVILLE PIKE, ROCKVILLE MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Obstructed Patron Men /Medical Immediata Causa (Final disease or condition resulting in deeth) Examiner Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown been signed by should be detec 1 Yes 2 No of Vital Records, þ 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? a No certificate 1 ☐ Yas 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) AND NO Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Division Hospital or Attending F 24 hours efter death. After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Diractor: / 3 ☐ Suicida 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29b. Signature and title of certify 29c. License number 29d. Data signed (Month, Day, Yaar) address of person who completed cause of death (Item 23a) (Type, Print) Georgetoun Rd. Betherds Je halman 941001 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 1999 Viola 5:30 AM Long January /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕮 F Months Yrs. 212-16-8593 Director Dec. 2, 1922 Maryland Usuel Residence of Decedent the Marylend 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23s or 28s-f show Examiner rount be notified at 1 XYes 2 No Directo Maryland Frederick Frederick 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with 1210 N. Market Street 21701 United States Funeral death 14. Rece - American Indian. 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 2 should be filed within 72 hours after end Mental Hygiena. Is marked other than "naturest", or its surretic event, the Medical Example. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 X Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Own Home permit. Pages 1 and 2 should be filled.
Department of Health and Mental Hygi important: If Item 27 is marked other any Injury or other traument. 18 Mother's Name (First Middle Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Norman Lawrence Blanche Feeser 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Frederick, Maryland 21702 Barbara Watson, daughter 505 Grant Place 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State 1/8/99 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 22. Name end Address of Fecility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Liperyees 1621 Opossumtown Pike Frederick, Maryland 21702 Approximete Interval Between Onset and Death th. Do not enter the mode of dying, such as cardiac or respiretory errest, **Physician** 5 Days /Medical immediate Cause (Fine) CEREBROVASCULAR ACCIDENT disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Leancocy tosis physician and the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Bacteremia Physician/Medical Due to (or as a consequence of): for use as 23b. Did tobecco use contribute to the cause of deeth? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by to 1 Yes 2 No 3 Probably 4 Unknown Schizophrenia py 24b. Were autopsy findings eveileble prior to completion of ceuse of death? should 24e. Wes en autopsy Completed page 2 s 1 Yes 2 No is certificata h 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medicel exeminer? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this After thi funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No death. Director: A investigation 2 Accident 6 Could not be determined n 24 hours efter der he Funeral Directo pletely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and place, end due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) Medical To the Hosp within 24 hor To the Fune completely fi 29b. Signeture end title of certifie 29c. License number 29d. Dete signed (Month, Day, Year) 143091 1-5-99

State Registrar 31. Dete filed (Month, Dey, Yeer)

32. Registrar's Signature

30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

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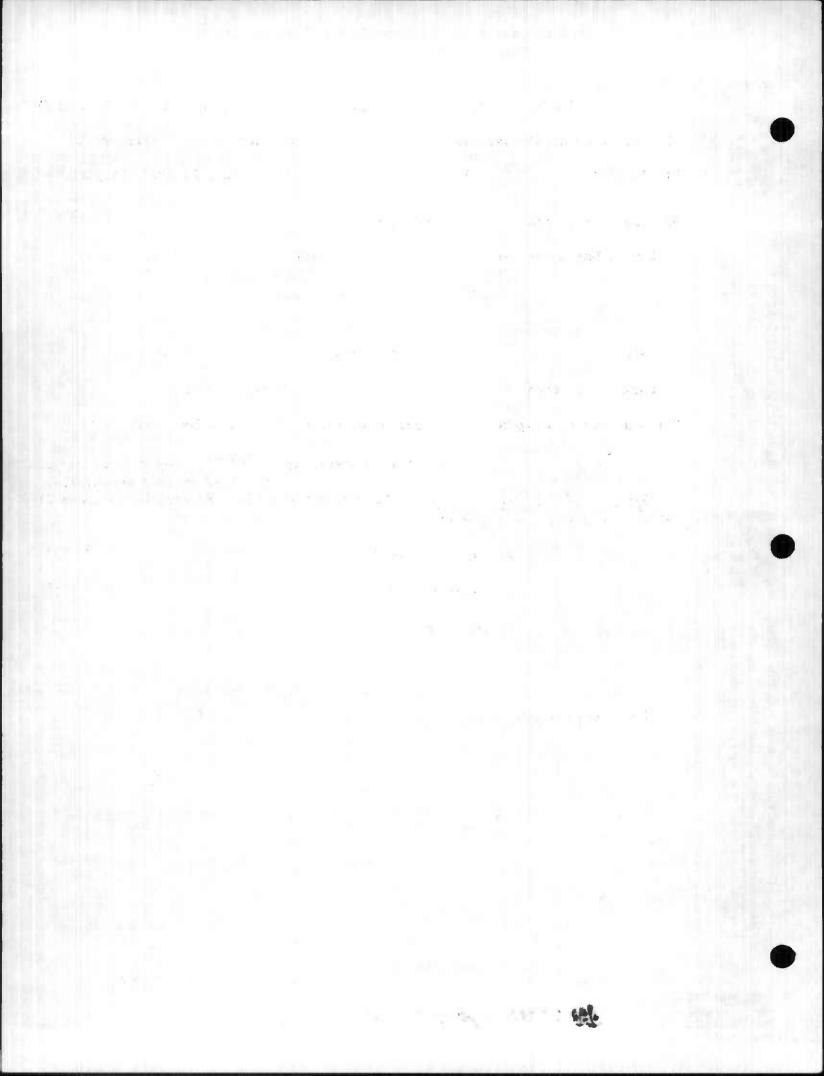
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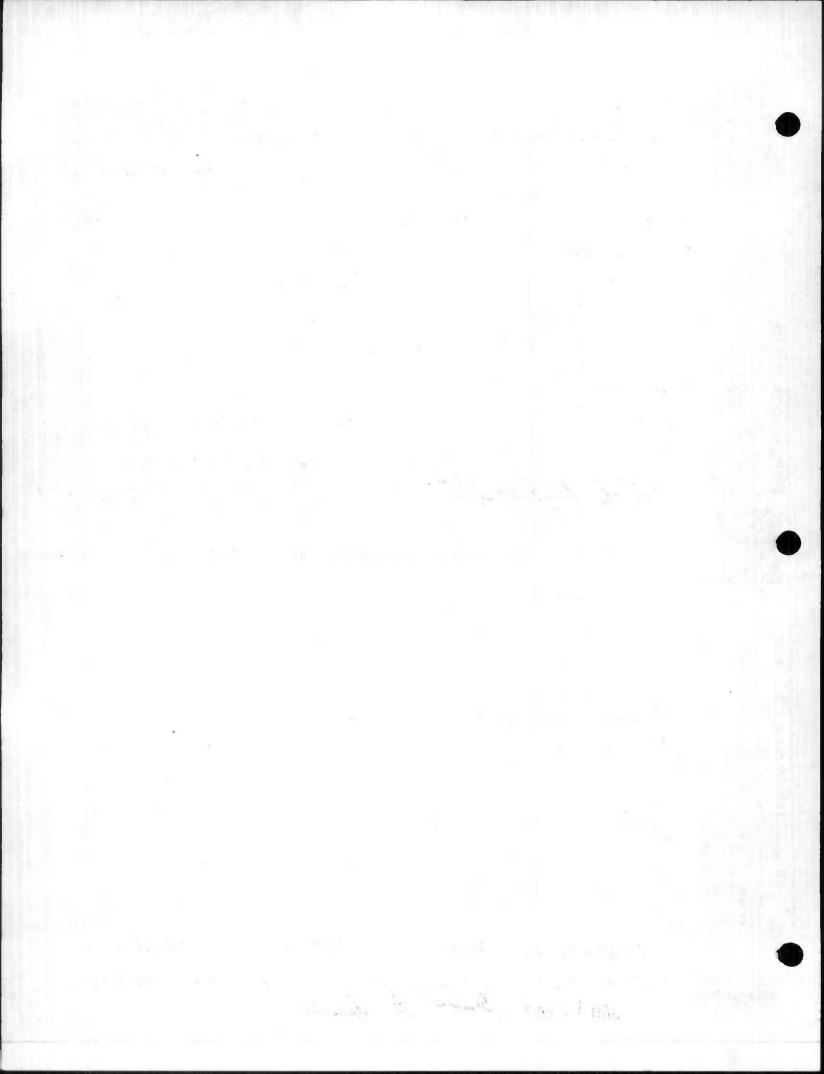
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HOUSE AVE, PREDERICH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Q Q Q G G G

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State Registrar

31. Dete filed (Month, Day, Year)

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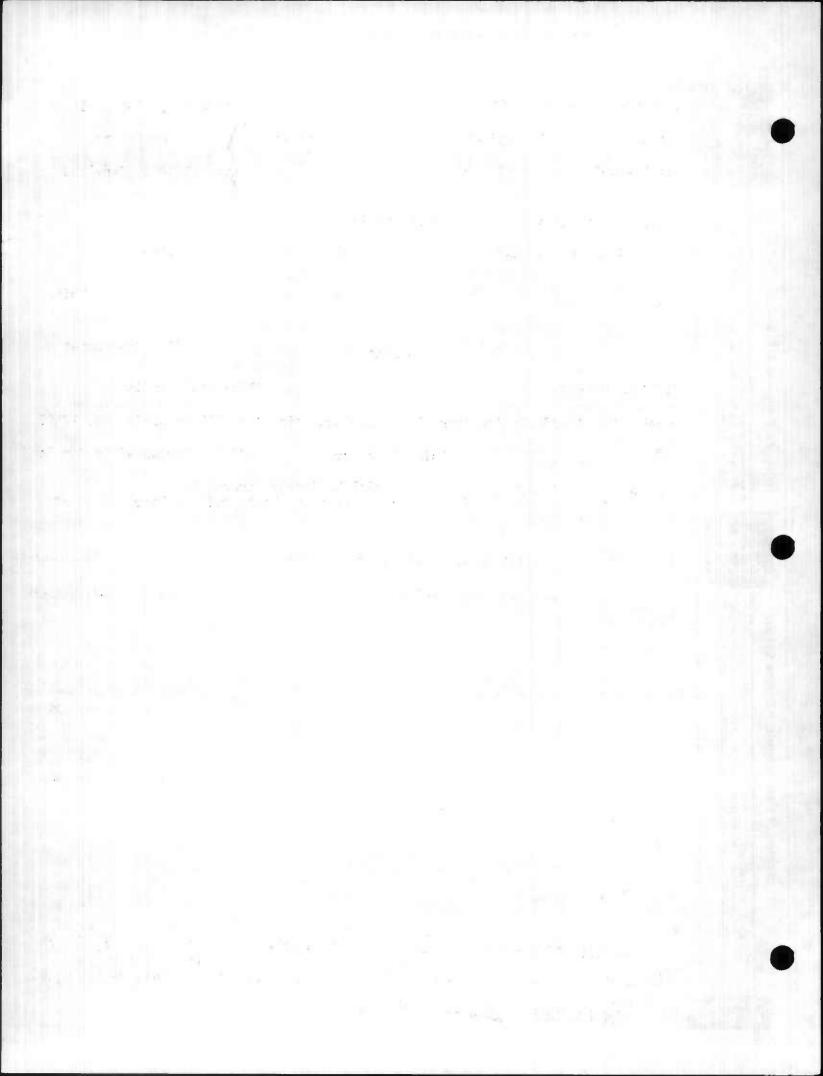
Dewett Mourism

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Bennett Morrison 2901 Olney - Sandy Spring Road, Olney, Maryland, 20832 32. Registrar's Signature

m1)

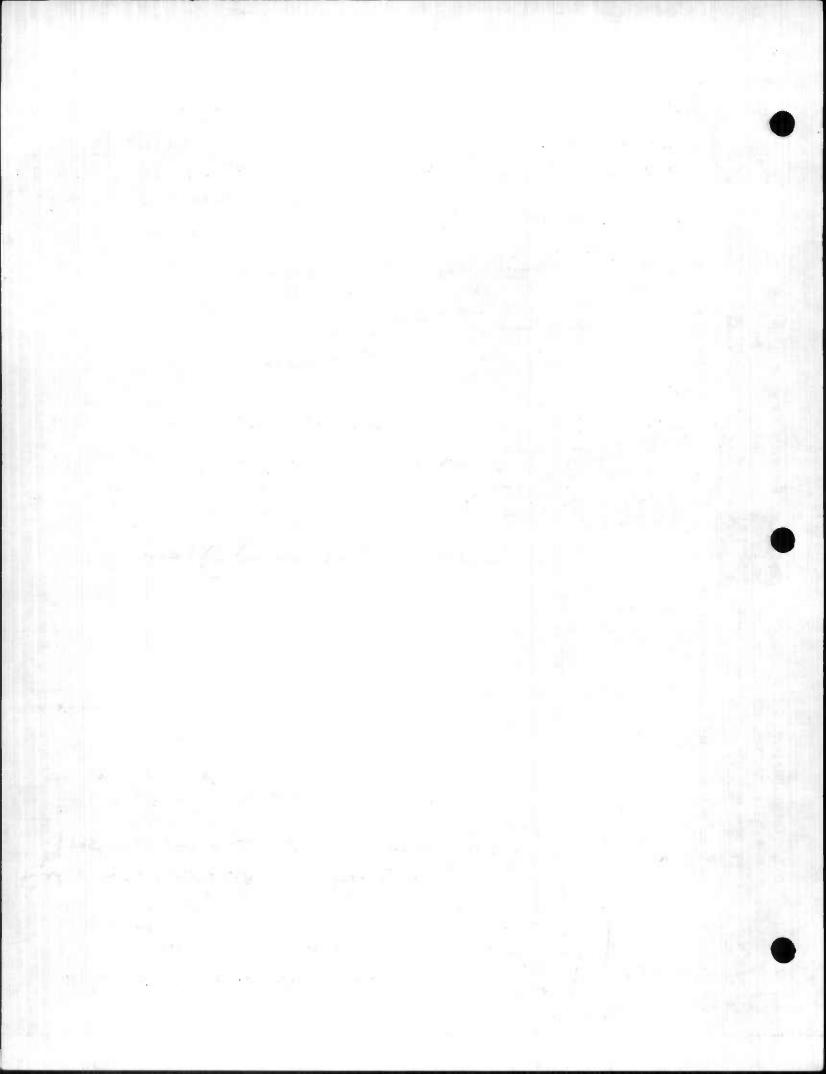
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lanuary



State of Maryland / Department of Health and Mental Hygiene

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	5. Social Security		6. Sex		7. Age ('In yrs. last bi		Under 1 Ye	ar If Under		8. Data of Birl (Month, Da			hplaca (State untry)	or Fore
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To	EDWIN MAY	YO							EDYTH	HE WH	ITLEY				
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		ano 8	Sch	Inch	/					1180	U NEW E	HAMPSHI	KE A	VENUE	
	to be as mili				V					SILV	ER SPRI	ING MAR	YLANI	D 2090	4-2
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edical Examiner	Immediate Cause disease or conditi resulting in death)	onditions, mmediata lerlying rinjury ts	a	ions that chause on Y	Du Du	tact ue to (or as a	consequen	nce of):		cardiac o	raspiratory a	rrest,		Approxim Interval B	ata
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	Decedant's Nama (First, Middle	a Lect)		Cer	tificate	e of	Death	2. Data of De	Reg. No.		3. Time of Death
Physician /Medical		Angel	La S. M	cArd1e				Month Januar	y 7, 199		12:52 PM
Examiner	4a Facility Nama (If not institution 5 Barkwood		nber)				4b. City, Town, or Rockvill		4c. County Montg		17
uneral	5. Social Security Number	6. Sex 1 □ M 2 🛱 F	7. Aga (In yrs.		If Under Months	1 Year Days	If Under 24 Hrs	8. Date of Bir	th		lace (State or Foreign
irector	335-14-3890 Usual Rasidance of Decedent	IUM ZKMF	7	/ Yrs.				June 13			llinois
B 19	10a. Stata 10b. County		10c. Ci	ty, Town or Loc	ation	74				1	Od. Inside City Limits
or 28a-f s be notified Directo	Maryland Montgo	omery	Ro	ckville		0.1			000		1 ☐ Yas 2 ☒ No
then I Dir	10e. Street and Number 5 Bas	rkwood Cou	ırt		10f. Zip	0853			10g. Citizen of V		
other must be notified at funer must be notified at Funeral Director	11. Marital Status		dent Evar in U	,S. 13. W			rispanic Origin? (S en, Mexican, Puer	Specify Yes or No to Rican, atc.)		e - Americ	an Indian,
by B	1 Navar Married 2 Marr 3 X Widowed 4 Divorced	ried 1 ☐ Yas	2 No		☐ Yes 2	22	Specify:		Specify		
Ner than 'natural, it its Medical.	15. Decedani (Specify only highas Elementary/Secondery (0-12)	st grada completed) College (1	-4or 5+)		and of wor ONOT us	k done e retire	pation during most of wo d)	rking	16b. Kind of Bu		dustry
other to	17. Fathar's Nama (First, Middla,	Last)		Home	make	r	18. Mother's Na	me (First, Middle,	Own H		
Sc ever		John Se	rvais			ď	Kathe	rine Tho	orn		
la ma	19a. Intormant's Name/Relations		200	19b. Mailing	g Address	(Street	and Number or R	ural Routa Numb	er, City or Town,	State, Zip	Code)
Day of	J. Terence McAn	rdle/Son	20h I	Mana of Diegoe	ition /Alan	20.06	urt, Roc	D-4-	Marylan 20c. Location -		0853
ant: If he lary or o	1 ☐ Burial 2 ☒ Cramation 4 ☐ Donation 5 ☐ Othar (S)		Stata	cematary, crem tropoli	atory or or	ther plac	^{ce)} January latory	10. 1999		- 1	Virginia
any in	21- Signature of Funerful Service	School	M00	846 Rol 300	pert A West	. Pu Mor				e, Indianylar	20850–2805
sician	23a. Part1. Eater the disease, of shock, or heart failure. List	complications to confice only one cause in a	aused tha deat ach lina.	h. Do not enta	r tha mode	e of dyir	ng, such as cardia	c or respiratory a	rrest,		Approximete Intarval Between Onset and Death
ledical aminer	Immediata Causa (Final diseasa or condition rasulting in daath)	Metas	tatic	Adenoca	rcino	oma	of Uteru	.S			2 Years
je je			Due to (d	or es a consequ	uence of):						
attending physician and for use as the bunal-transit clar/Medical Examiner	Sequantially list conditions, if any, leading to Immadiata causa. Enter Undarlying	b	Dua to (d	or as a consequ	uence of):		4.19				- Rig
ng physicians the bu	Cause (Disaase or injury that initiated events rasulting in daath) Last	c	Dua to (c	or as a consequ	ance of):						
for use		d								I I	
igned by the attending physical be detached for use as the by Physician/Medic	Part It. Other algnificant condition An emia	ons contributing to de	ath but not res	ulting in tha un	derlying co	euse giv	ven in Part I.				the cause of death?
been signe should be d		mbooda of	Loc	38				24a. Wes	an autopsy	24b. We	ere autopsy findings ailable prior to
page 2 should	Deep Vein Thro	OMDOSIS OI	Leg						110	of	mpletion of cause death?
	25. Was casa referred to medical						26 Place of Do	ath (Check only o		1[☐Yas 2☐ No
or, pag	examinar?	Hospital:	npatient 2	ER/Outpatient	3□ DO	A Oth	nor.	Home 5 X Resi		er (Specif	(y)
is certificate director, pag To Be Co	1 ☐ Yas 2 🕅 No		of Injury	28b. Tima of	2	Bc. Injui		28d. Describe	how injury occur	red	
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State

Registrar DHMH 16 Rev 6/95

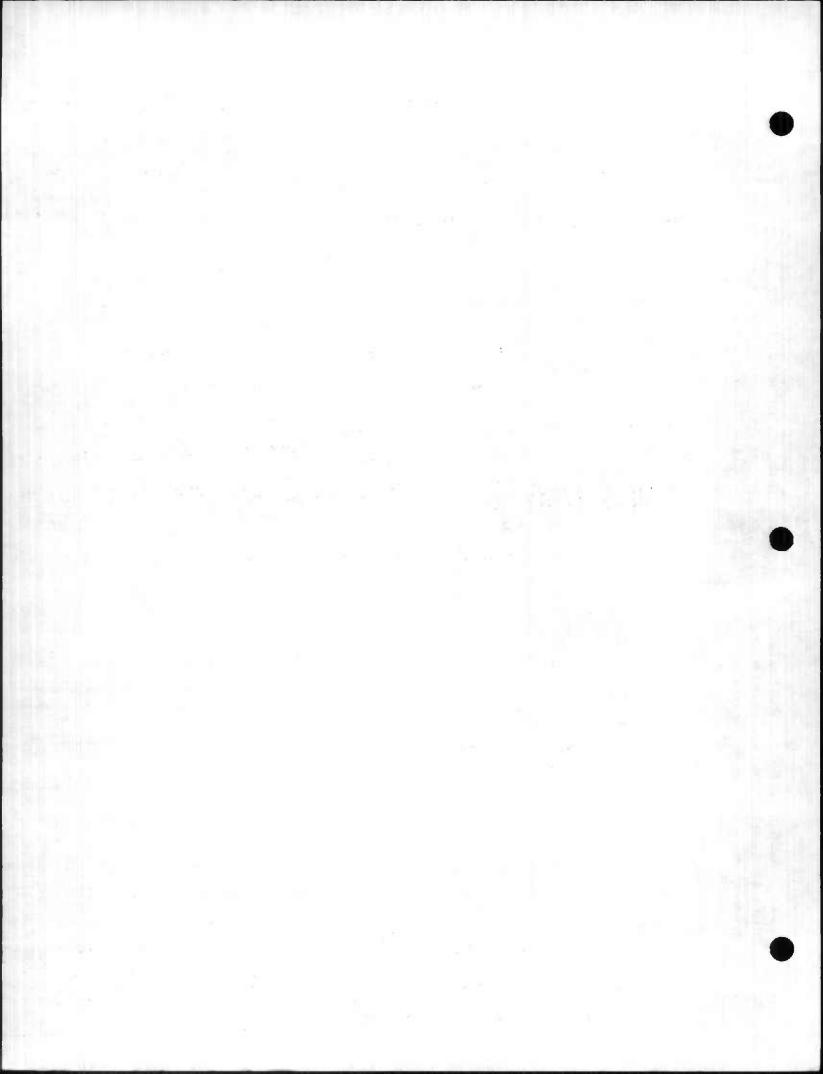
Philip G. Henjum, M.D., 3416 Olandwood Court #204, Olney, Maryland 20832

31. Data filed (Month, Day, Year)

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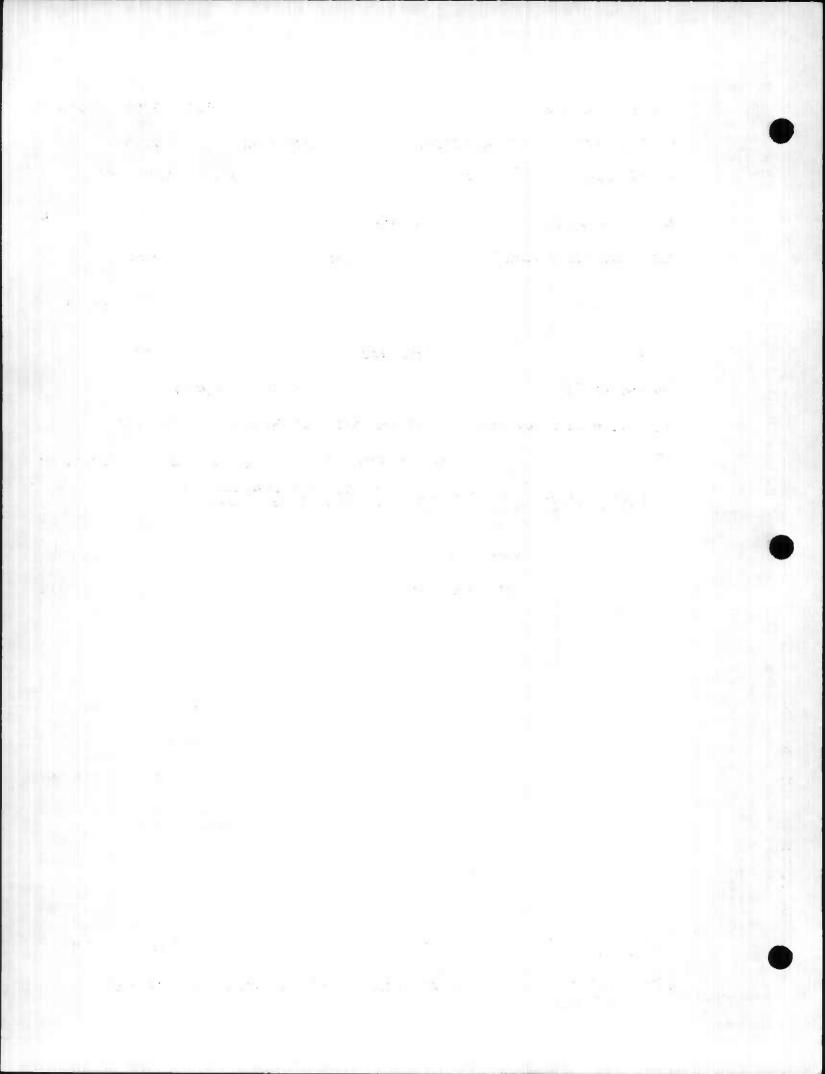
32. Registrar's Signatura

A. Apocks



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Physician					Cert	illicate C	of Death		leg. No.		T (D)
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uneral Pirector	5. Social Security Nur 214-36-65 Usual Rasidenca of D	94 1	өх Ом Х О F	93	. last birthday) _ Yrs.	Months Da			, 1905	Country) MD	(State or Foreign
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rec liec	10e. Sfreet and Numb					10f. Zip Cod	le		l0g. Citizen of V	Vhet Country?	
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o B	Manuel H	Keefer					Ida Be	11 (Snyde	r)		
	19a. Informant's Nam	e/Relationship (7	Type, Print)	100	19b. Mailing	Addrass (Str	eet and Number or I	Rural Routa Numbe	r, City or Town,	Stata, Zip Coo	la)
r tra	Hilda B.	Walker-	-daughte	r	21230	4 Hill	Road SW;	Rawlings	, MD 2	1557	
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Important: If item 27 any injury or other to once.	21. Signature of Fund	ral Seprice Licen	see M	ALO	A) 22.	Nama and Ad Scarpe	Idrass of Facility	al Home,			
sician	23a. Part1. Entar tha shock, or haar	disaasa, or comp feilure. List only	olidations that cal one cause on ea	used the las			land, MD dying, such as cardi	21502 ec or respiratory an	rast,	Inta	proximata arval Between set and Death
edical miner	Immadiata Causa (Fi disaesa or condition rasulting in daath)	nal	a. PNEUM		or as a consaqu	uanca of):				2 V	NEEKS
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or the burial-transit	Sequentially list cond	litions.	b		or as a consequ	uenca of):					
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	that initiated avants rasulting in death) La		d	Due to (or as a consequ	ence of):					
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by Physician/M								1981	res 2□No	3 Probabl	y 4 Unknow
should should								24e. Wes perfor	an autopsy mad?	availat	autopsy findings bla prior to etion of causa th?
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E 0	25. Was casa rafarre- axaminar?	d to medical					26. Pleca of D	eeth (Check only o	na)		
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atlon:	2 Accidant	5 Panding invastigation		Injury , Day Year)	28b. Tima of Injury		njury at Work? 1 □ Yas 2 □ No	28d. Dascribe h			
ed in by the	3 ☐ Suicide 4 ☐ Homicide	6 Could not be datarmined	28a. Placa o building	of Injury - At I g, atc. (Spec	noma, farm, stra	at, factory, olf	ica	28f. Location (S City or Ton	itreet and Numb m, Stata)	er or Rural Ro	uta Numbar,
pletely fill edical				is of examin		estigetion, in n	e tima, data and ple ny opinion, daath oc	curred et the time, o	date end place,	and dua to the	cause(s)
£ 2	29b. Signatura Ind. tit	la of certifiar	Tunan	M	D		ense number		29d. Deta signe		, Year)
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nes	30. Name and eddres	s of person who	completed cause	of deeth (Ite	m 23a) (Type, F				•		-



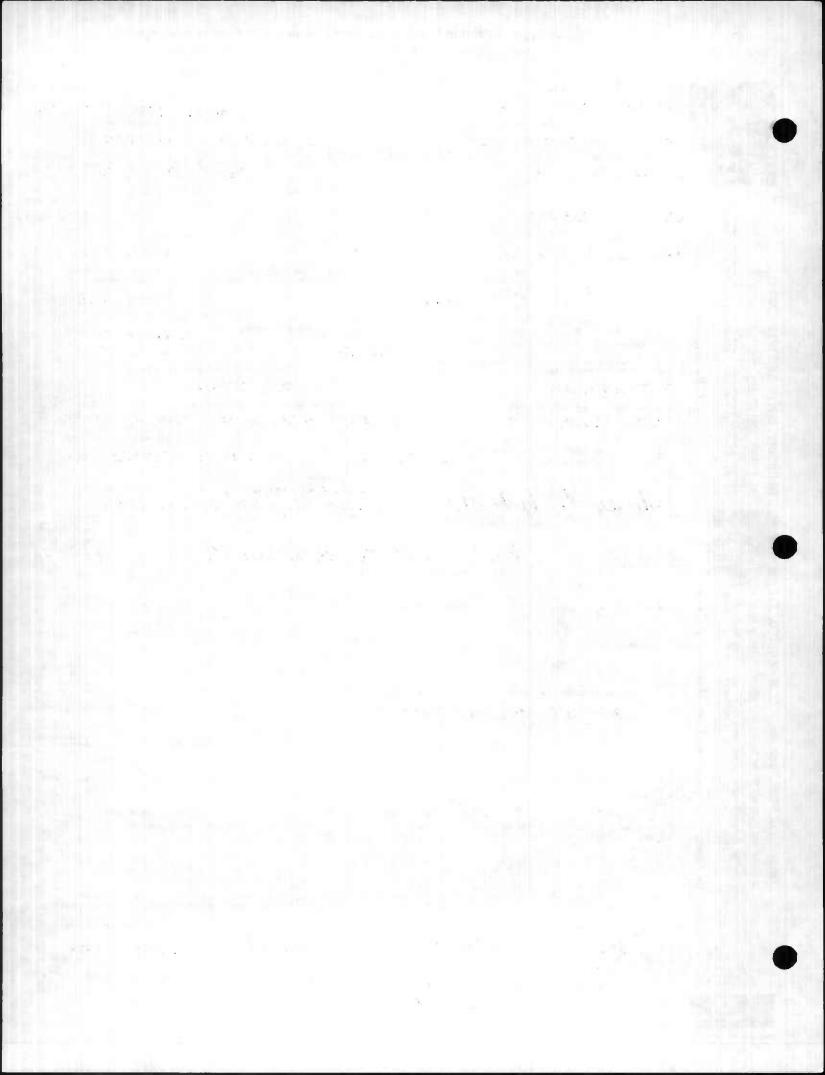
State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3 Time of Death **Physician** DAVID DAYTON MILLER **JANUARY 7 1999** 12:45PM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) July 9,1924 If Under 1 Year Birthplaca (State or Foraign Country)
 MARYLAND 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1₹M 2□ F Months Days Hours 74 Yrs. 217-14-4887 Director Usual Residence of Decedent with the Meryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at MD ALLEGANY CRESAPTOWN 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21502 U.S.A. 14203 LOUISE DRIVE, SW Funeral death 12. Was Decedent Evar In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelih and Mental Hygiene.
Important: If item 27 is marked other than "naturel", or iter any injury or other treumatic event, the Medical Example once. 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates: Maryland 21215-0020 1□ Yes 21 No Specify: WHITE þ W.W.II 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry KELLY-SPRINGFIELD Elamantary/Secondary (0-12) College (1-4or 5+) MACHINIST TIRE COMPANY 12 18. Mothar's Nama (First, Middla, Maldan Surname) 17. Father's Name (First, Middle, Last) DAVID LOT MILLER EMILY DAYTON 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FLORENCE MILLER / WIFE 14203 LOUISE DRIVE, SW-CRESAPTOWN, MD 21502 Baltimore. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MSVC-ROCKY GAP 1/11/99 FLINTSTONE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice License 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximate tnterval Betwean Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in daath) /Medical ACUTE BACTERIAL MENINGITIS Examiner Examiner physicien end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury Dua to (or as a consequence of): certificete be exec Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 88 for the Part II. Other significant conditions contributing to death but not resulting in the undariying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? PO 1 Yes 2 No 3 Probably 4 Unknown signed by MELLITUR TYDE IT þ Records. 24b. Were autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? Completed certificate hes 1 Yes 2 AK 1 Yes 20 No Division of Vital Be 25. Was casa rafarrad to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 10 1 Yas 2 LNo 1 Dippatient 2 ER/Outpatient 3 DOA sins funeral 27. Manner of Death 28b. Time of tnjury 26d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: or Attending Feffer death.

Director: After 1 Destural 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be datarmined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours Funerel 1 Certifying Physician: To the best of my knowledga, death occurred at the tima, date and place, and dua to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PATYSICIAN JANUARY 7 1999 6 no until ddrass of person who completed cause of death (ttem 23a) (Type, Print) 912 SETUN PRINE CUMBERCAND, MO 21502 TUNS LOVERIA JR. M.O JOSE 7 31. Date filed (Month, Day, Year) JAN 1 1 1999 22. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Time of Death **Physician** Sylvia Clark McCoy January 9m 1999 /Medical 12:00 p.m. 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Cumberland If Undar 24 Hrs. 8. C Hours Min. Cumberland Nursing Center Allegany If Under 1 Yaar 8. Data of Birth (Month, Day, Ye 5-23-08 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) PA **Funeral** 1□ M 20XF Months Days 90 Yrs. Director 177 50 7010 Usual Rasidance of Dacedant the Maryland 10a Stata 10b. County 10c. City, Town or Location "natural", or items 23e or 28a-f show edical Examiner must be notified at 10d. Inside City Limits Be Completed by Funeral Director MD Allegany 1 X Yas 2 □ No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Winifred & Williams Streets 21502 USA Pages 1 and 2 should be filed within 72 hours eftar death nent of Health and Mental Hygiane. Int: If Itam 27 is marked other than "natural", or Itams 23. Iny or other traumatic event, the Medical Exertinal nearly. 12. Was Decedant Evar in U,S. Armed Forcas? 1 □ Yes 2 ☒ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Orlgln? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarlcan Indian, Black, Whita, etc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 X No Specify: specify: White 3 Widowed 4 □ Divorced 15. Decadant's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) Homemaker Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) James H. Clark Grace (nmn) Stair 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Marjorie M. Shroyer RD # 1, Hyndman Road, Hyndman, PA 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Cooks Mills Cemetery 1-11-99 Hyndman RD, PA 21. Signature of Fi 22. Nama end Addrass of Fecility Harvey H. Zeigler Funeral Home Hyndman, PA 15545 Hyndman, PA 15545 List only ona causa on aech lina. Approximeta Intarval Between Onsat and Death **Physician** /Medical Immadiata Cause Fina acuna diseesa or condition rasulting in death) **Examiner** Examiner Hospital or Attending Physician: The law requires that the death certificata be assecuted 24 hours efter death. Funeral Director: After this certificate has been signed by the attending physician and Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting In daath) Last Physician/Medical Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the Chronic lymphocytic leukasuna. 1 Yes 2 No 3 Probably 4 Unknown p 99 Congestire beauffailure Completed 24b. Wara autopsy findings evailable prior to completion of ceusa of daath? 24a. Was an eutopsy performed? this certificata has 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medicel examinar? Be 26. Placa of Daath (Check only ona) Certification: To 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Deeth 28c. Injury at Work? 28d. Dascribe how Injury occurred Natural 2 Accidant 5 Panding Invastigation 1 ☐ Yas 2 ☐ No filled in by the 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

29a. Cartifian

31. Data filed (Month, Day, Year)

29b. Signature end titla of certifier

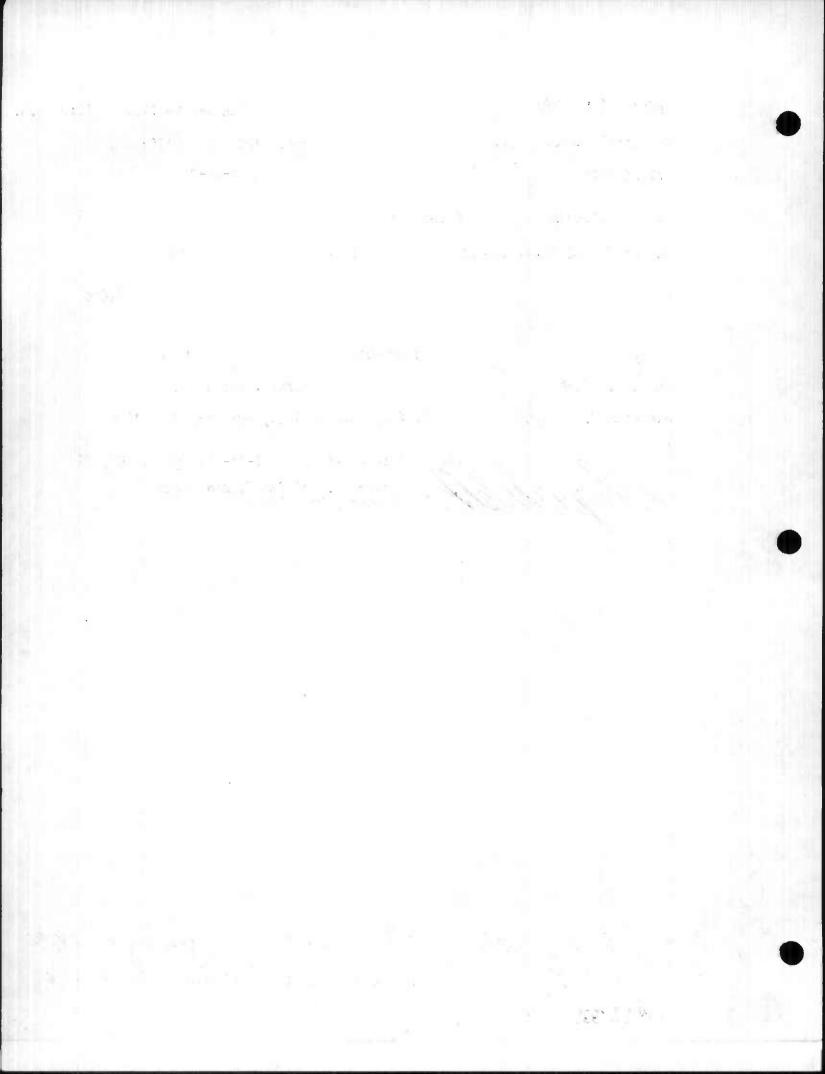
30. Nama and address

Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

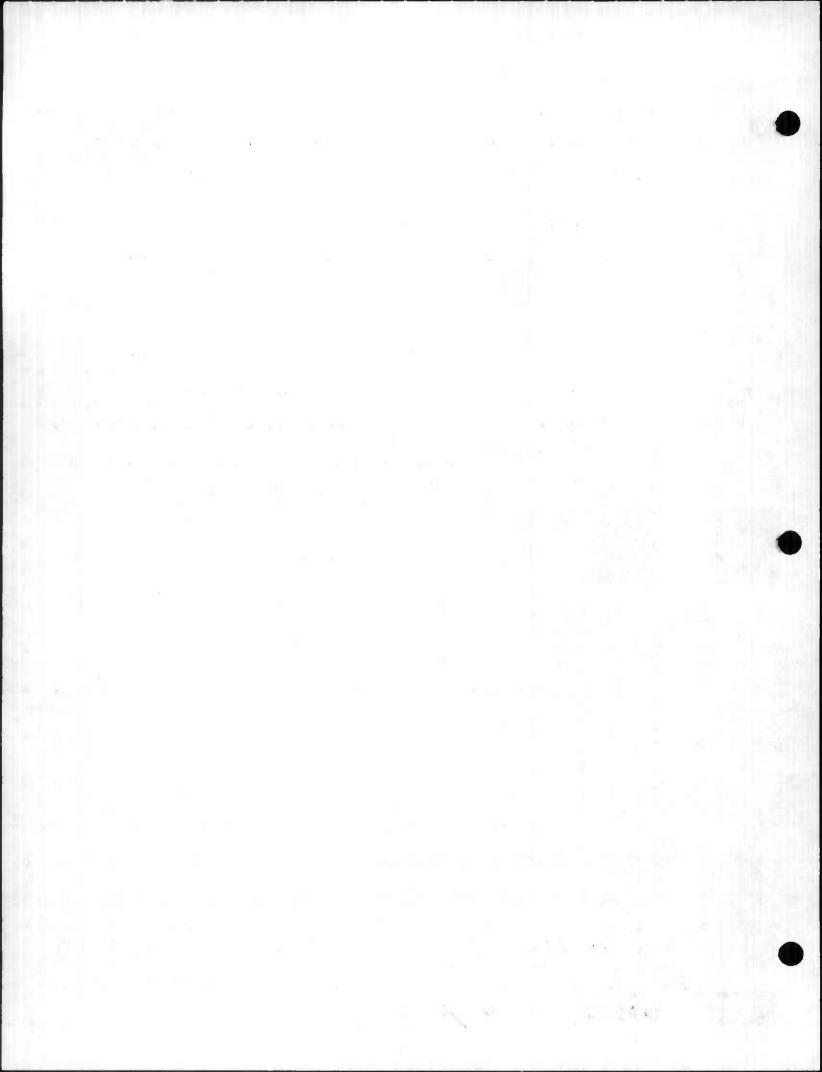
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licensa number

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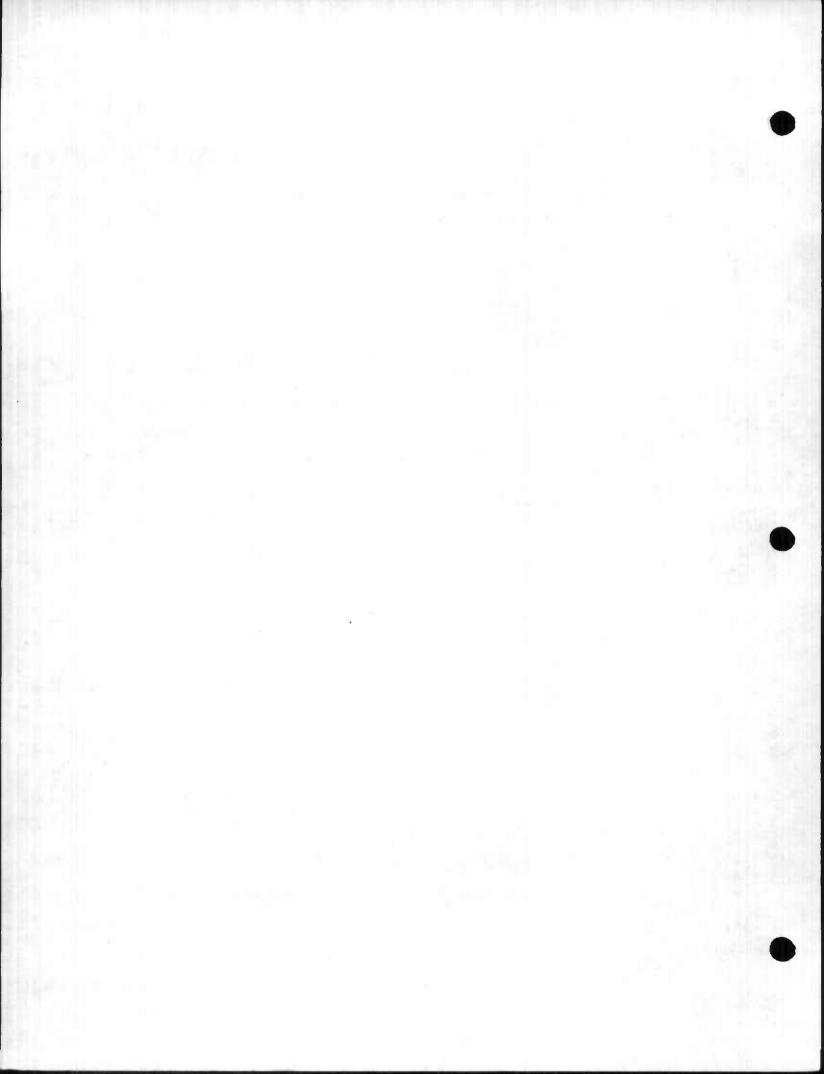
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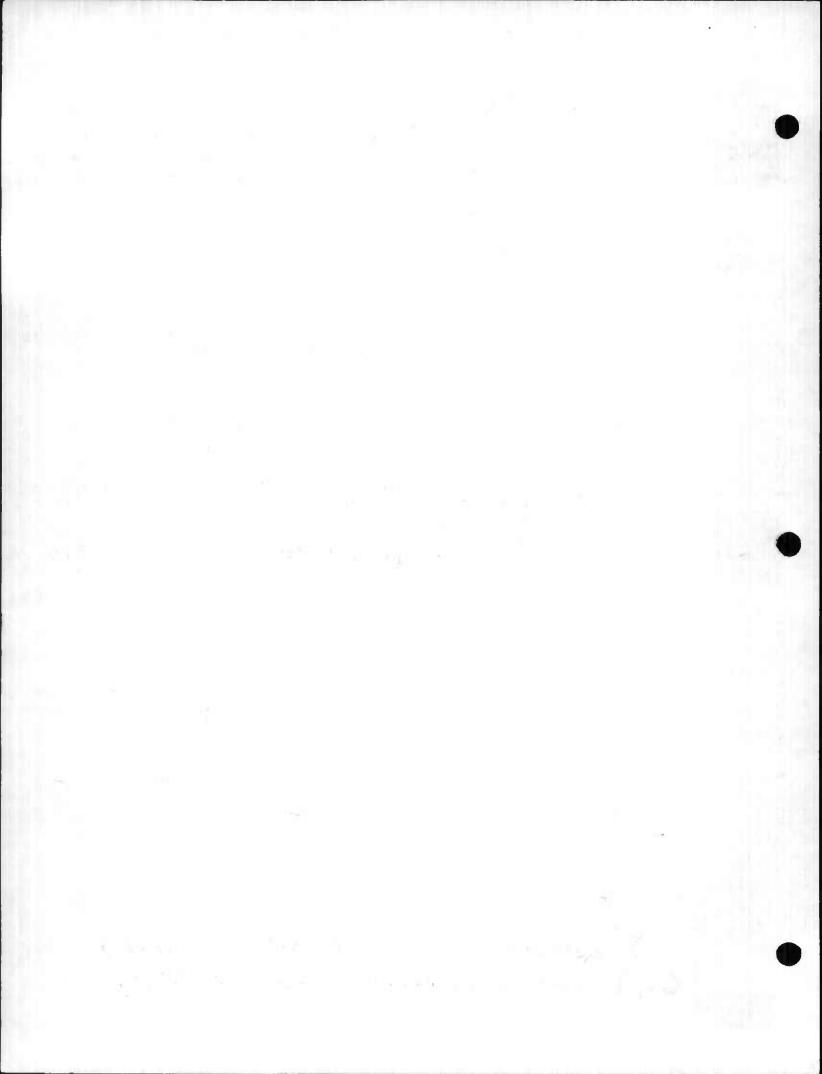
Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** JAN 1999 RUTH ELIZABETH MOULDEN 10:00 A.M. /Medical 4b. City. Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner ALLEGANY 12907 CLIFFSIDE ROAD MT. SAVAGE If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 XF Yrs Director NOV 10 1925 MARYLAND 24 3166 Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Director MARYLAND ALLEGANY MT. SAVAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23a or 12907 CLIFFSIDE ROAD 21545 U.S. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify à 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Deptiment of Health and Mental hygient Important: if item 27 is marked other that any follury or other traumatic event, that pace. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be GROVER HORINE ANNIE PALMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) PHILIP MOULDEN / SON p. o. box 450, MT. SAVAGE, MD 21545 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify) SUNSET MEMORIAL PARK 1/7/99 CUMBERLAND, MD 21502 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical 10 cman Examiner Due to (or as a consequence of) Examine physician and s the buriel-transit certificate be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 88 981 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed Deen has page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred To the Hospital or Attanding is within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 T Homicide Dentifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29e. Certifier completely (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of dertifier 5 30. Nema and address of person who completed cause of death (Item 23a) (Type, Print) This 420 502 (VIKRAMADITYA POONAI, M.D. 31. Dele filed (Month, Dey, Year) 32. Registrer's Signeture JAN 0 6 1999 Registrar



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										Reg. No.		
Physici	ian	Decedent's Name (First, Middle, II JANE CELIDA II							inte of De Month	Day	Year	3. Time of Dea
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Funeral Director		199-22-3011	1 N VIII	e (In yrs. lest bii 70	Yrs.	lonths Deys	If Under 2 Hours	Min.	Dete of Bir (Month, Di	rth sy, Year) 30,1928		piece (Stete or Fo ntry) ennsv-L-v
ž		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	wn or Location	ion			L			0d. Inside City L
8a-f sho	ector	Md. Talbo	ot		ston							Yes 2
23a or 28a-f show ust be notified at	Funeral Director	10e. Street end Number 822 N. Washii	ngton Str	eet	1	10f. Zip Code 2160	01			U.S.		ntry?
or items	by	11. Maritel Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 H Yes, Give Yeer or Dates:		If Ye	s Decedent of Hes, specify Cub	en, Mexican	nn? (Speci , Puerto Ri	fy Yes or No can, etc.)		ck, White,	can indian, etc. nite
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f Health and Mental Hygiena. Item 27 is merked other than other traumatic event, the M	To Be	Victor Deppe	,						Husar		,	
and N		19a. Informant's Name/Relationship	(Type, Print)	19t	b. Meiling A	Address (Street	t end Numbe	r or Rural F	Poute Numb	er, City or Town,	Stete, Zip	Code)
of Health ar Item 27 is r other trau		Mrs. Sandy Ca	arlo-Daug	hter	813	Church	h Hil	l Rd	.,Cei	ntrevil	le,	Md. 21
Department of important: if any injury or once.	W 1	23a. Part1. Enter the disease, or co shock, or hear fallure. List on	mplications that caused by one cause on each lin	the death Do	40	8 S. 1	Liber	ty S	t., (Newnam Centrev	rille	e, Md. Approximete
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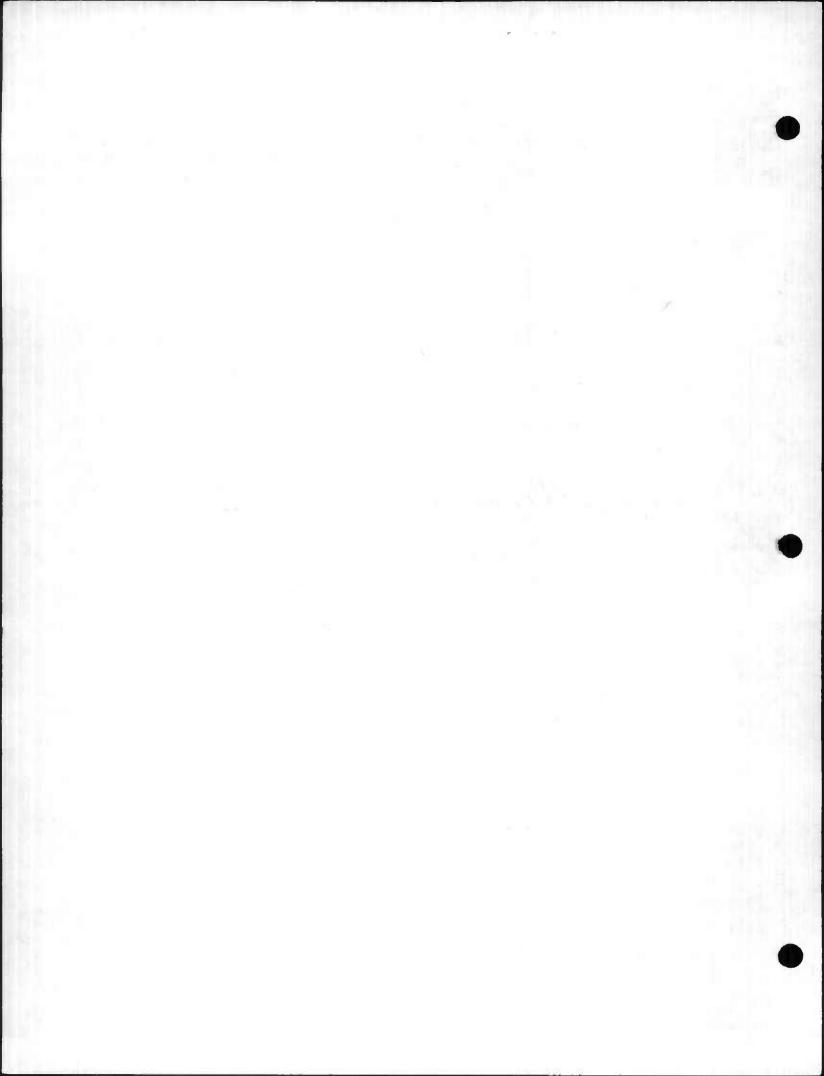


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physiclan** BERNADETTE GRAHAM MAGROGAN 5:20AM Jan.7,1999 /Medical 4e. Facility Name (If not institution, give street and number) Genesis Elder- 4b. City, Town, or Location of Death 4c. County of Death Examiner are-Medidian of Corsica Hills Centreville Queen Anne's ff Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 214-32-2206 Months Days 83 Director 15,1915 Maryland Usual Rasidence of Decedant the Meryland 10a. Stete 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Express results to retified at 10d. Insida City Limits Md. Director Queen Anne's 1 Yas & No Queenstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 1 838 Del Rhodes Ave. 21658 U.S.A. Funeral death 1 11 Maritel Status Wes Decedant Evar In U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian Black, Whita, atc. be filed within 72 hours efter 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2√2No If Yas, Give 21215-0020 1 Yas XXNo Spacify White þ Specify: 3 Widowed 4 □ Divorced Yaar or Datas: Completed 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry al Hygiene. Elamantary/Secondary (0-12) Coilaga (1-4or 5+) Restaurant Cook Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental In Important: if them 27 is marked ott any injury or other traumatic even once. Be Medford B. Graham Margaret Ann Schauber 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Louise Remmert-Daughter 1702 Kirk Rd.; Glen Burnie, Md. 21061 Baltimore, 20b. Piece of Disposition (Nama of camatary, cramatory or other place) Jan. 17, 1999 Location - City or Town, Stata 20a. Mathod of Disposition XBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) St. Peter's Cemetery Oueenstown, Md. 22. Name end Addrass of Fecility Fellows, Helfenbein & Newnam Funeral HOme 408 S. Liberty St., Centreville, Md.

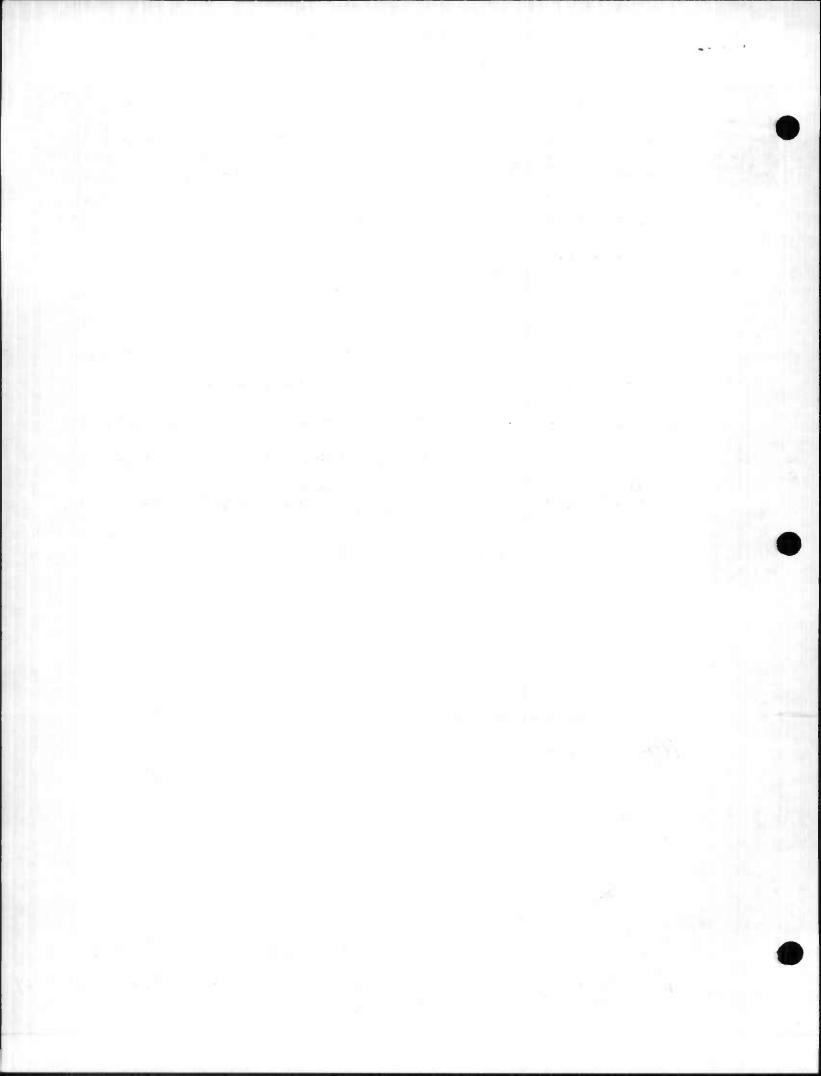
Do not antar tha moda of dying, such as cerdiac or raspiratory arrest,

Approximat Approximata Intarval Betwaen Onsat and Death **Physician** Immediata Causa (Fine) diseesa or condition rasulting in daath) /Medical **Examiner** Examiner Sequentially list conditions, if any, leeding to immediate ceusa. Entar Undarlying Causa (Diseese or Injury that initiated evants resulting In daath) Last Box 68760. nding physician The lew requires that the death certificete be Physician/Medical Due to (or as a consequant P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Records, þ Completed eral Voscular disease with 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yas 2 No 1 Yas 2 No Division of Vital or Attanding Physician: Be 25. Was cese referred to medical 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Marsing Homa 5 Residence 8 Other (Specify) ို 1 Yas 2 No this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how Injury occurred Aftert 5 Panding invastigation 1 Maturel death. 1 Yes 2 No 2 Accident within 24 hours efter deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 6 4 Homicida 1 To entitying Physician: To the bast of my knowladge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Cartifian (Check only the 29b. Signatura epotitla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year) sell a. Ely H-42587 Jan. 7, 1999 30. Nema and addrass of parson who completed ceusa of deeth (item 23a) (Type, Print) Russell Schilling, M.D.; 2540 Centreville Rd.; Centreville, Md. 21617 31. Data filed (Month, Day, Yaar) 32. Registrar's Signatura State Registrar JAN n 8 1999



State of Maryland / Department of Health and Mental Hygiene 9 9 0 1 6 1 6

						Certific	ate of	Death	R	eg. No.	U	1010
	Physici	an	1. Decedent's Name (First, Middle, La	•			. 300		2. Date of Dea Month	th Day	Yeer	3. Timii iif i leeth
	/Medi		Theresa	Bramble M	leekin	S			January			5:57 M
	Examir		4a. Fectity Neme (If not institution, git	ve street and number)				4b. City, Town, or	Location of Deeth	4c. County	of Death	
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	uneral irector	1	214-07-7107	1□M 2MY	e (in yrs. last b	Yrs. If Ur Mont	hs Days			Year) 1908		lace <i>(Stete or Foreig</i> try) yland
pue	*		Usual Residence of Decedent 10a. State 10b. County		10c City To	wn or Location					1/	0d. Instde City Limits
faryte	a or 28a-f show be notified at	5	Maryland Wicomic	0		alisbur	**				"	11/21/Yes 2 □ No
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eth with	23a or		1514 Riverside				218			0g. Citizen of V	vnat Coun	try r
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryland the and Mantel Honisons	rene. In Medical Examiner mark	by Funeral	11. Marital Status 1 ☐ Never Merried 2 ☐ Married 3XXVidowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Y	Ever in U,S.		specify Cul	Hispanic Ortgin? (S ban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - America k, White, e : W	
2-C	Pice	Completed	15. Decedent's E (Specify only highest gr	ducation	16	a. Decedent's U	Isual Occu	pation	rkina	16b. Kind of Bu	istness/ind	lustry
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should be	marked	2	Grant Bramble					Lydia	Pritchet	t		
2 she	EE		19a. Informant's Name/Relationship		19	b. Meiling Add	ess (Stree	t and Number or R	ural Route Number	, City or Town,	State, Zip	Code)
6.7	n 27		Linda M. Buob D	aughter				iars Road	d Salisbu	ry, Mar	ylan	d 21801
o se	if item 2 or other		20a. Method of Disposition XIX Burtel 2 ☐ Cremation 3 ☐	Removal from State		of Disposition (lery, cremetory				20c. Location -	City or To	wn, State
Pag	ant: ury		4 ☐ Donation 5 ☐ Other (Special	(y)	Dorcl	hester	Memor	ial Park	1/12	Cambrid	lge, l	Maryland
permit. Pages 1 er	Important: If ite any injury or of		21. Signature of Funeral Service Lice			Trib		ess of Fecility neral Hor	me, P.A.			
Phy	/sician		23a. Part Enter the disease, or come short or heart failure. List only	ptications that caused one cause on each lin	the death. Do	o not enter the r	LOCUS node of dy	t Street ing, such as cardia	Cambridg c or respiretory err	e, Mary	Land	Approximete Interval Between Onset end Death
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deeth certificate be axecuted	0 6	Medicai	resulting in death) Last		540 10 (01 40 5	. comoquomou	J.,.					
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requires	been sig should b		Atrial Fibre	2					24a. Was a perform		ave	ere autopsy findings ellabte prior to impletion of cause
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Physicien:	is certificate director, pag	Be	25. Was case referred to medical examiner?						eth (Check only on	e)		
hysle	o 10 ₪	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/C	Outpatient 3	DOA O	ther: 4 \substack Nursing t	Home 5 Reside	ence 6 Othe	er (Specify	1)
gu .	r. After the funerel		27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigatio	28a. Date of Injur (Month, Day	Year) 28b.	Time of Injury M	28c. Inju	uryat ork?]Yes 2 ☐ No	28d. Describe ho	ow injury occurr	ed	
- 5 E	in D	Certification:	3 Suicide 6 Could not be determined		ry - At home, (Specify)	farm, street, fac	tory, offica		28f. Location (St City or Town		er or Rure	Route Number,
the Hospital	To the Funeral C completely filled	edical	29a. Certifier (Check only one)	nysician: To the best of niner: On the bests of and manner sta	examination a	ge, deeth occurr and/or tnvestiget	ed at the t ion, In my	ime, date end place opinton, death occ	e, end due to the curred at the time, d	euse(s) and me ate and plece, o	nner as st and due to	ated. the cause(s)
To the	To th	Me	29b. Signature and fittle of certifier				29c. Licen	se number	2	9d. Date signed	Month, I	Day, Year)
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		-	20. Name and address of account	- S	ath (the ac	\(Time= Pare)	P	777	7	1//	1/7	/
			30. Name end address of person who	completed cause of de	Time .		2/1	Divis	. (1	5-1-	1	Mn n.p.
	.01		31. Date filed (Month) Bak (Yelr)	1000 20 Bodes	r's Signature	13	1	DIVIS	on at.	J415.	Dury !	MD 2180
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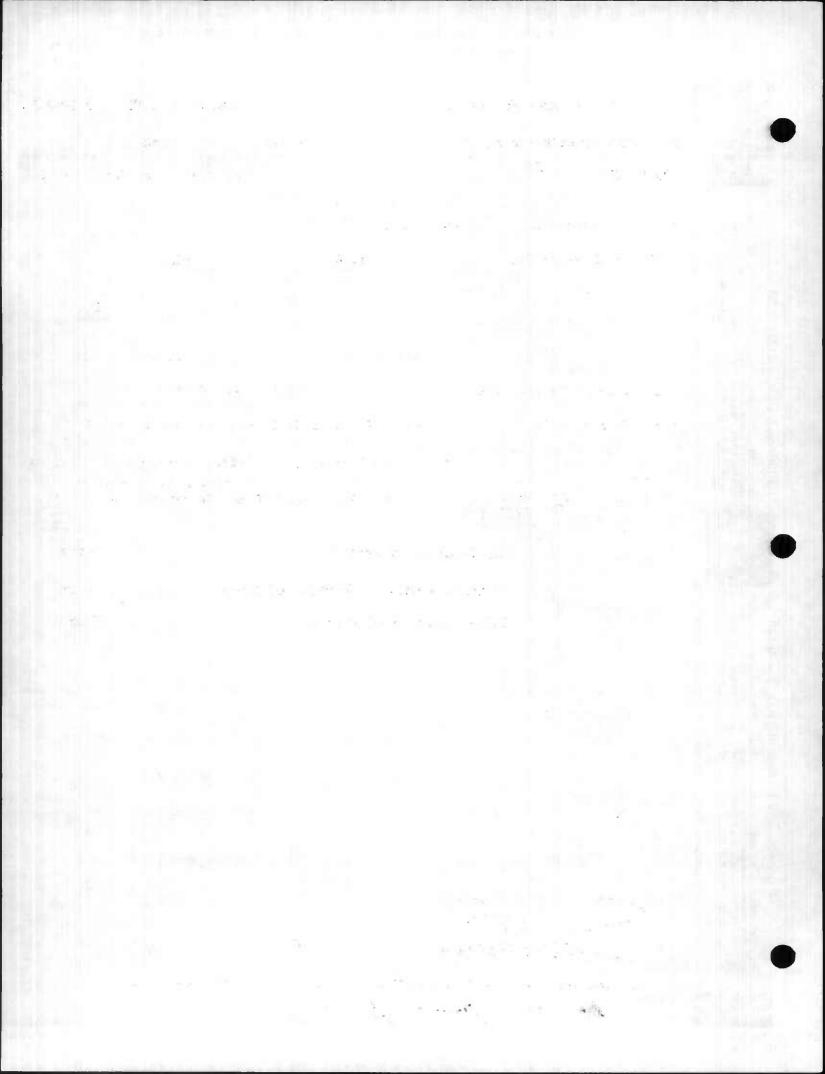


State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth January 5, 1999 Year **Physician** William James McCrea, IV 3:39 A.M. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Deys 1 N M 2□ F Months Hours Min Yrs. Director 209-50-0850 38 Sep. 30, 1960 Pennsylvania Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits worke "naturel", or items 23s or 28s-f show 1 ☐ Yes 2 X No Directo Maryland Frederick New Market 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 10704 South Glade Court permit. Pages 1 and 2 should be filed within 72 hours effar death v Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 21774 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
tf Yes, Give
Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: PV 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Controller 5+ Restaurant 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) William James McCrea, III Shirley Jean Duff 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robin McCrea, wife 10704 South Glade Court, New Market, MD 21774 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Buriel 2 X Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown Crematory 1/9/99 Hagerstown, Maryland 22. Name end Address of Fecility Stauffer Funeral Home 23a. Pert1. Enth the disease, or complications that all sed the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or man failure. List only one cause on much line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Hours Cardiopulmonary arrest Examiner Due to (or es e consequence of): Examine Probable sepsis/perforation of bowel Hours death certificate be executed physician and s the bunal-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) Inflammatory bowel disease Years Box 68760. Physician/Medicai Due to (or es e consequence of) for use as 88 P.O. by the e 23h. Did tohecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown Hypertension thet Division of Vital Records, by law requires 24b. Were eutopsy findings evellable prior to completion of cause of deeth? should 24a. Wes en eutopsy performed? Completed page 2 s The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No this certificata Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: or Attending 1 Neturel 5 Pending 1 Tyes 2 No death. investigetion Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide efter fo the Hospital or within 24 hour To the Fr within 24 hours of To the Funeral D completely filled is critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I was call Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie edical 29b. Signature and field 29c. License number 29d. Date signed (Month, Day, Year) 1/8/94 D50207 30. Name end eddress of person who completed call to all disast (Item 23e) (Type, Print) Samuel Eng, M.D. 610 Solarex Court, Frederick, Md. 21703

32. Registrar's Signature

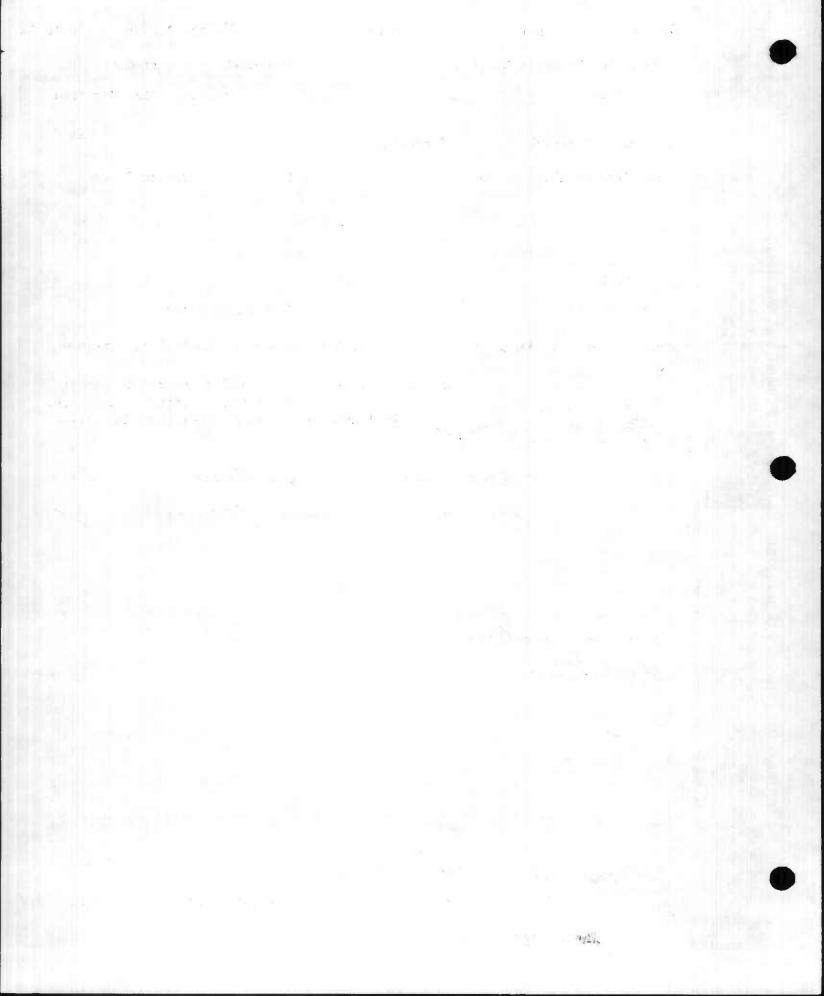
State Registrar



State of Maryland / Department of Health and Mental Hygiene

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aminer	4a Facil	ity Name (If	not institution	n, giva str	reet and nun	n <i>ber)</i>				4b. City, Tov	vn, or Lo	cation of Dea	th 4c. 6	County of	Deeth	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Hester Baden Morse 4, 1999 4:35 am Jan. 4a. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Shady Grove Nursing Center Rockville Montgomery 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1□M 20 F Months Deys Hours Yrs. 038-09-4344 92 Jan. 1, 1907 Wash., D.C. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Boyds 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 17311 White Grounds Rd. 20841 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yes, Give Was Decedent of Hispenic Origin? (Specify Yas or No. If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, etc. 1 Never Married 2 Married 1□ Yes 2⊠ No Specify White 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grede complated) College (1-4or 5+) Elementary/Secondery (0-12) Housewife Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Charles Baden Edith Pickney 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John S. Waring / son 17311 White Grounds Rd. Boyds, Md. 20841 20b. Pieca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 1/6/99 Berryville, Va. 4 ☐ Donetion 5 ☐ Other (Specify) Enders/Shirley F.H. 21. Signature of Fun 22. Name and Address of Facility Hilton Funeral Home Box 86 Barnesville, of the other the mode of dying, such as cardiac or respiratory 20838 23a. PartT. Enter the disease, or complications that caused the death. Do not enter shock, or heart feilure. List only one cause on each line. Approximate interval Betw Onset and Death immediate Cause (Final TNEUMONIA diseese or condition resulting in deeth) Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequença of): Due to (or as a consequence of). 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🌣 Unknown Lung

Physician /Medical Examiner

end

Physician

/Medical

Examiner

MD

Director

Funeral

by

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

deeth

filed within 72 hours after

Pages 1 and 2 should be

I Hygiene.

and Mental I

nt of Health a: If Rem 27 is

permit. Page Department of Important: If any Injury or

other

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other (traumatic event,

21215-0020

Baltimore, Maryland

the burial-trai attending physician for use as the buria Physician/Medical been signed by t should be detect by Completed Be 2 Certification: within 24 hours attar daatt To the Funeral Director: completely filled in by tha

has

this certificata

Affer

daath.

The law requires that the death certificate be asscuted

Records, P.O. Box 68760,

Division of Vital or Attending Physician: Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

28e. Dete of injury (Month, Dey Year)

FRACTURB_

5 Pending investigation

6 Could not be determined

25. Wes case referred to medical

1 Yes 2 No 27. Manner of Deeth

1 Naturel

2 Accident

4 ☐ Homicide

3 Suicide

29a. Certifier (Check only one)

CHRONIC OBSTRUCTIVE CONGECTIVE HEART FAILURB

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 275 No 1 Yas No

26. Piace of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Continuo Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) end manner es steted.

Madical/Examíner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end manner steted. 29d. Data signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

29b. Signature and title of 29c. License number D 28656

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) AVENUE # 404 B. SILVER SPRING, MD20910 SECOND VASSO 8609

28b. Time of

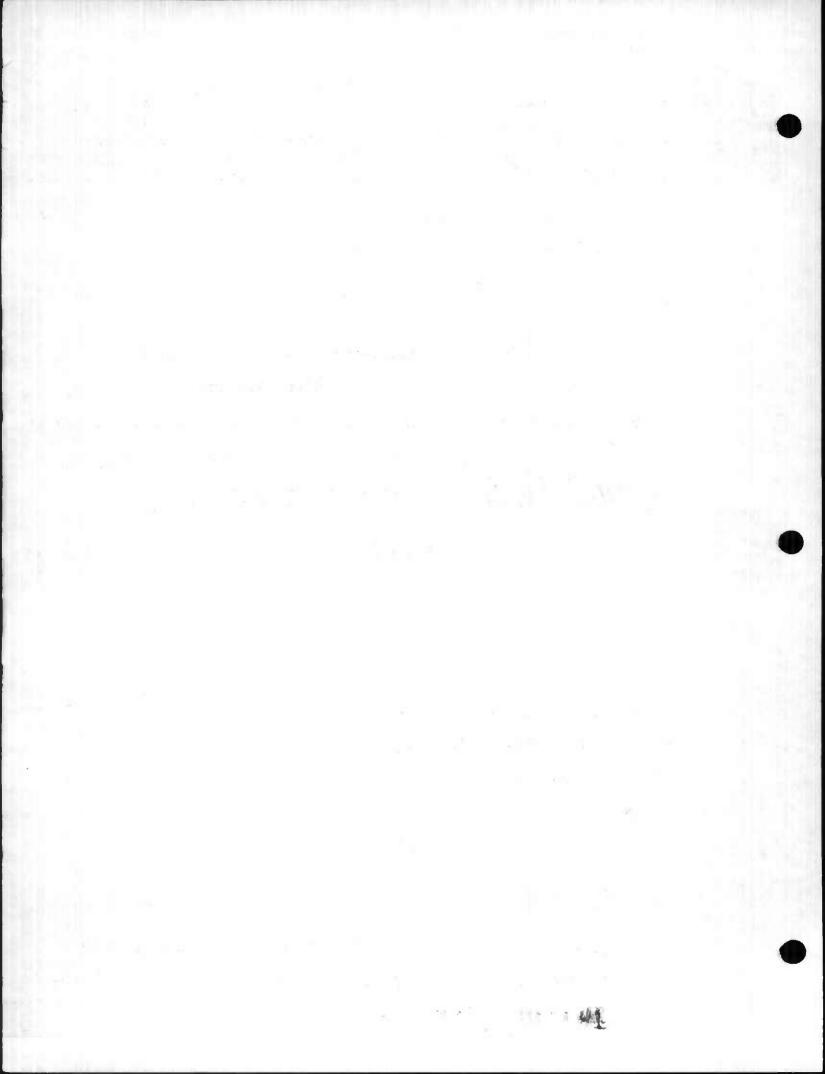
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28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

State Registrar

Medical

31. Dete filed (Month, Dey, Year) 32. Registrer Signature



State of Maryland / Department of Health and Mental Hygiene Q 01620

ITEMS: #1.	23. 27. 28A-F PER MEO G	772 6-29-99 WF	. C	ertifica	ate of	Death		Reg. No.	010	C he C
Physician	1. Decedent's Nama (First, Middla, Las	it)					2. Data of Do Month	eath Day	Year	3. Tima of Death
/Medical	LAWSON S.D. N	OEL					JAN.	. 02,	1999	0945 AM
Examiner	4a Facility Nama (If not institution, give	street and number)				4b. City, Town, o	Location of Deal	th 4c. County	of Death	
	MARYLAND CORREC		NING CE		der 1 Year	HAGERS			INGTON	
Funeral Director	5. Social Security Number 6. S 218 17 1443	DM 2DF	In yrs. last birthdi 23 Yrs	Month			Septemb	oer 7,		ce (Stata or Foreign
pue *	10a. Stata 10b. County	1	Oc. City, Town or	Location					10d	I. Inside City Limits
natural, or items 23s or 28s-f show dies Examine must be northed at the first between the profile of the first by Funeral Director.	MD Montgom	ery	Silve							1∭Yes 2□No
3a or 2 st ban	10e. Street and Number 3802 Tremayne Te:	rrace			Zip Code			10g. Citizen of Trinida		
al, or items 23a or 28a-f show the circumst be nothed at by Funeral Director	11. Marital Status 1 ☑ Nevar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yas, Giva Year or Dates:	er in U,S. 1	3. Was Dec	-	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0- 14. Rad Bla	ce - American ck, White, atc y: Blac	Indian,
natural', adical Euclieted by	15. Decedant's Ed		16a. De	cedent's U	sual Occu	pation	. 4 i	16b. Kind of B	usiness/Indus	stry
then dm	(Specify only highest gra Elamantary/Secondary (0-12) 1 2	College (1-4or 5+)				during most of w ed) presenta		Budget	Rent-	A-Car
	17. Father's Nama (First, Middla, Last)			,,,,,,	10	_	ama (First, Middle			11 001
2 · ·	Robert Noel					Ruth	Charles			
EĘ	19a. Informant's Name/Ralationship (7	ype, Print)	19b. M	ailing Addre	ess (Stree	at and Number or I	Rural Routa Numb	per, City or Town	, Stata, Zip Ci	ode)
	Ruth Noel/Mother		3802	2 Trem	nayne	Terrace	Silver	Spring,	MD 20	906
or other	20a. Mathod of Disposition		20b. Place of Di	sposition (A	lama of	ace)	Data	20c. Location	- City or Town	ı, State
ITY OF IT	1 DaBurial 2 Cramation 3 4 Donation /5 Other (Specify	Hamovai Ironi Stata				Cemetery	1/11/99	Silver	Spring	, MD
Important: If any Injury or once.	21. Signature of Fune all Service Licen	67/-	of	McGui	ire F	ess of Facility uneral S				0010
	23a, Parti, Error the disaasa, or comp shock, or hear tailure. List only					ia Avenu				0012 oproximata
edical miner aminer	Immediate Cause Final disease are conditions and rasulting in desire. Sequentially list conditions,	b	ON e to (or as a con a to (or as a con							
e as the burial-transit Medical Examiner	Sequantially list conditions, it any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated avents rasulting in death) Last	c	e to (or as a con:	sequence o	f):					I JEH
attendir for use		0							1	
achec hysi	Part II. Other significant conditions co	ontributing to death but r	not resulting in th	e underlyin	g causa g	iven in Part I.		tobacco use co Yes 2□ No	ontribute to the	he cause of death? bly 4 ☐ Unknown
should be								s an autopsy ormed?	availa	a autopsy findings able prior to pletion of cause ath?
te hes page 2							100	Yas 2 No	101	Yes 201 No
ertifica ector, p	25. Was casa raterred to medical					26. Place of D	eath (Check only	one)		
To E	examiner?	Hospital: 1 Inpatient	2 ☐ ER/Outpa	tient 3	DOA O	ther	Homa 5□ Ras	idence 6 DOI	rectionar (Specify)	nal facility
neral	27. Mannar of Death	28a. Data of Injury (Month, Day Y	ear) 28b. Time		28c. Inju	ury at ork?	28d. Describe	how injury occu	rred	TUCTITLY
or: Al tha fu	1 Natural 5 Panding 2 Accidant invastigation	1-2-99	5:30	М		Yes 2 No	SUBJEC	T STRANGLE	D.	
Certification: To Be Comp	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homlcida detarmined	28e. Place of Injury building, atc. (CORRECTION)	Specify)	street, fact	ory, office			(Street and Number, State) MD.		
completely filled in	29a. Cartifier 1 Certifying Phy (Check only one) 2 Medicat Exam	raician: To the best of n iner; On the basis of ax and mannar stated	ny knowledge, de amination and/or	eath occurre r investigati	ed at the t	ima, data and place opinion, death oc	e, and due to the	cause(s) and m	annar as state	led.
To the Funeral Direction of the Completely filled in the Medical Certi	29b. Signatura and titla of certifiar	wind internal sides		2	29c. Licen	ise number		29d. Data signe	ed (Month, De	sy, Year)
. 0	Theodon H	fire me	6		0.	C.M.E.		JAN. 4		
	30. Nama and addrass of person who o									
	THEODORE M.K.			Penn	Stre	et, Balt	imore,Ma	ryland	21201	
State	31. Data filed (Month, Day, Year)	32. Registrar's	Signature	4	1	19,				

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State of Maryland / Department of Health and Mental Hygiene O Items: 8,20b per F.H G-768 2/10/99 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** January 11, 1999 10:15 AM Ethel M. Numrich /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11104 Waycross Way Kensington Montgomery If Under 1 Year 8. Date of Birth May 4, If Under 24 Hrs 5. Sociel Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours 1 ☐ M 2 🖾 F 93 Yrs. 1905 **Director** 098-01-1444 Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 11104 Waycross Way USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: P 3 ☑ Widowed 4 Divorced White Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry New York State Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglens important: If itsm 27 is marked other the early injury or other traumatic event, traumatic event, traumatic event, traumatic event, traum Government 12 Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Patrick Aloysius Mimnaugh Catherine McGowan 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 20895 Susan K. Numrich (daughter) 11104 Waycross Way, Kensington, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 1/18/99 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Gate of Heaven Cemetery 1/15/99 Silver Spring, MD 4 □ Donation 5 ☒Other (Specify) Entombment 22. Neme and Address of Fecility Francis J. Collins Funeral 21. Signature of Funeral Service Licensee Home, Inc. 500 University Blvd. West Silver SPring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Finel most & disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted avents resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 6 1 Yee 2 No 3 Probably 4 Unknown signed to Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 € No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Wes case referred to medicel examiner? 26. Place of Deeth (Check only oper) Other: 4 Nursing Home 5 Aesidence 6 □Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To # 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Altor Attending 5 Pending Injury 1 Natural death. Investigation 1 Yes 2 No n 24 hours after death the Funeral Director. A plately filled in by the 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stele) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 edical 29e. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as steted. miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the P within 2 To the P 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 4e 930 at alma NLL 5530 C 16

Registrar

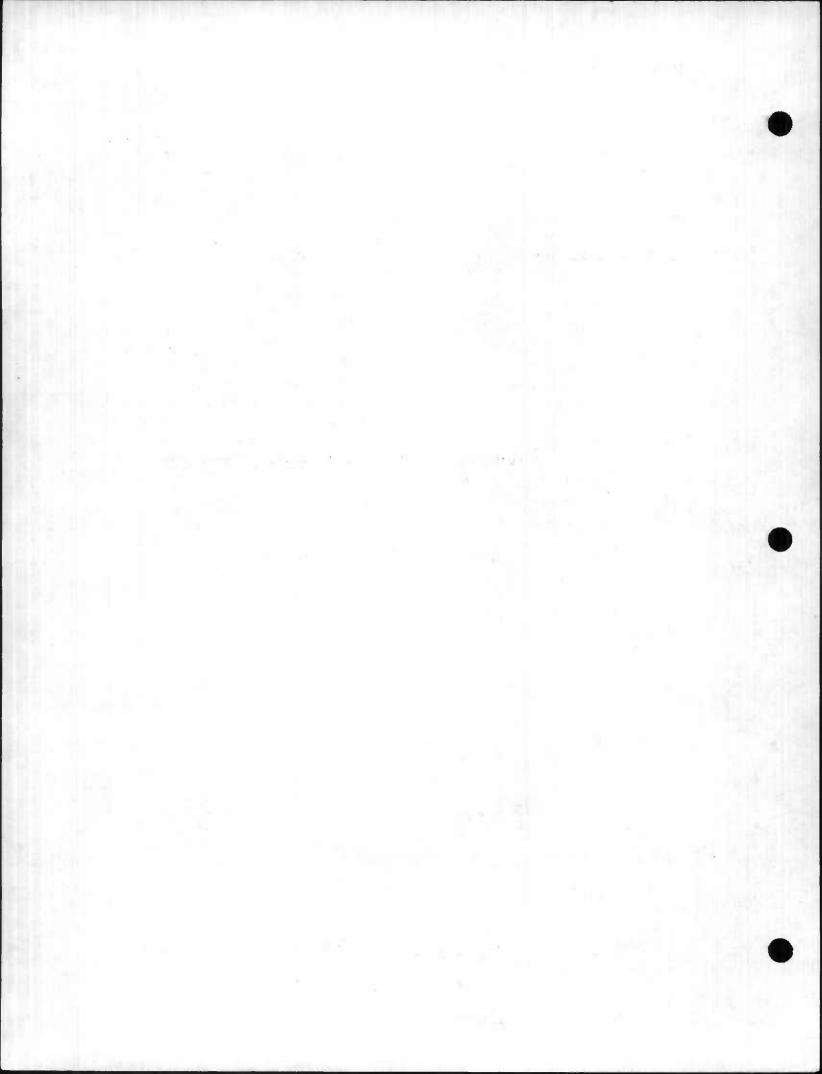
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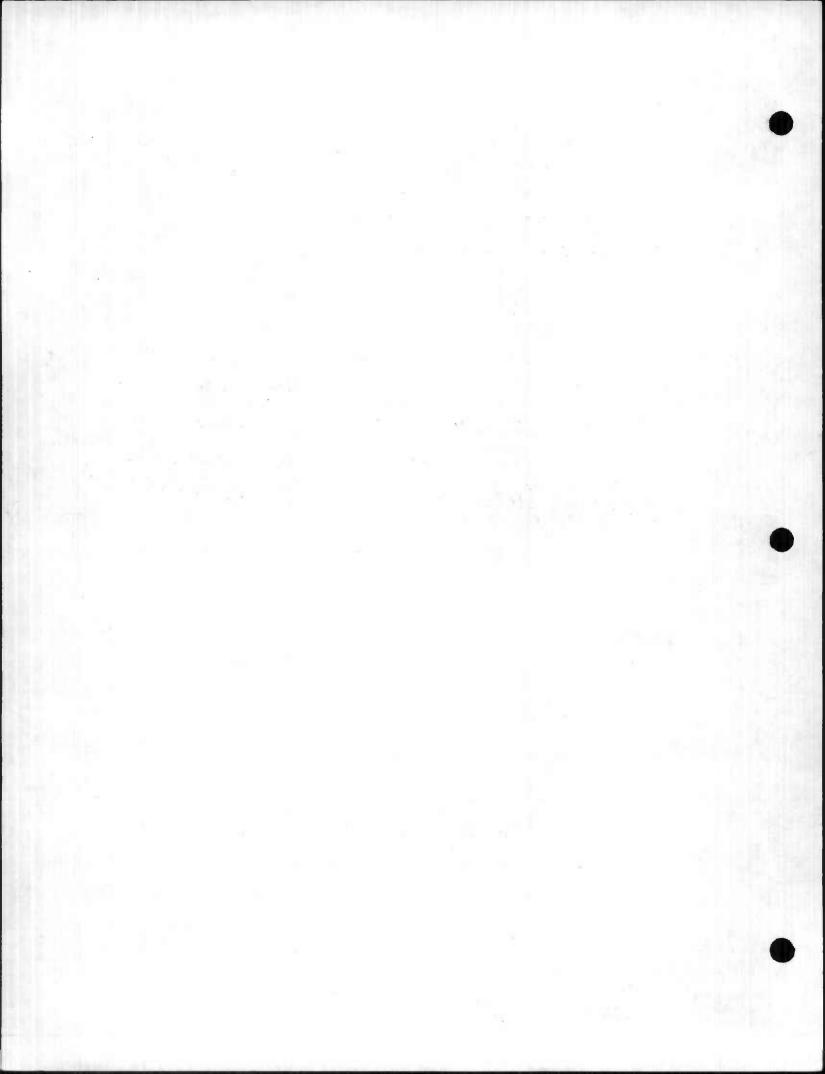
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32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

	Decedent's Name (First, Middle, Last		C	ertificate of	f Death	2. Date of Dea	leg. No.	010	me of Death
Physician						Month	Day	Year	D. D. C. C. C. C.
/Medical	Albert Napolitano					January			:35 PM
Examiner	4a Facility Name (If not institution, give					Location of Death	4c. County	of Death	
	SHADY GROVE				ROCKV			ITGOMER	
Funeral Director	5. Sociel Security Number 009-03-0987 Usual Residence of Decedent	M 2□ F 7. Age (In yrs. last birthda 87 Yrs.	Months Day			, 1911	9. Birthplace (S Country) Vermont	itate or Foreign
DA I	10a. State 10b. County	1	Oc. City, Town or	Location				10d. Ins	ide City Limits
n /2 nours are resum with the maryland "natural", or items 23s or 28s-1 show sidest Example must be notified at leted by Funeral Director	MD Montgom	erv	Gaithe	rsburg				10	Yes 2 No
r 28s	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?	
iner met be nothed iner met be nothed Funeral Director	18700 Walker Choi	ce Road, A	pt. 225		20886		J	JSA	
ner ner	11. Maritel Stetus	12. Was Decedent Ev Armed Forces?	er in U,S. 1	B. Was Decedent of	Hispanic Orlgin? (5 ban, Mexican, Puer	Specify Yes or No-	14. Race	a - American Indi	an,
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No		to rican, etc.)	Specify	k, White, etc. White	
P	15. Decedent's Edu		16a. Dec	cedent's Usual Occ	upation		16b. Kind of Bu	siness/Industry	
Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Gi	ve kina of work don . DO NOT use retir	upation e during most of wo red)	rking			
Con	, (, , , ,	4		mic Engi	neer	15,541	Federal	L Govern	ment
Be	17. Father's Name (First, Middle, Last)				18. Mother's Ne	me (First, Middle,	Maiden Sumem	e)	
2	Luigi Napolitano			TE OF LEE	France	sca Falza	arano		
	19a. Informant's Neme/Reletionship (Ty				et and Number or R				
	Albert G. Napolit	ano (son			er Lane,				
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ R	emoval from State	20b. Place of Dis cemetery, c.	position (Neme of rematory or other p	(ace)	Date	20c. Location -	City or Town, Sta	ate
	4 Donation 5 Other (Specify)	Jan Jan Jan			emetery				
9000	21. Signature of Funeral Service License	Putou	11		ress of Facility F				al
ian	23. Parth. Enter the disease, or complished, or heart feilure. List only or	dations thet caused the cause on each line.					rest,	Interv	eximate el Between end Death
lical iner	Immediate Cause (Final disease or condition	Myocard	ial Infa	rction				10	days
1.0	resulting in death)		e to (or as a cons	Control State Control					
- el).						i	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du	e to (or as a cons	equence of):					
edical	triat initiated events	Du Du	e to (or as a cons	equence of):					
	resulting in death) Last								
by Physician/M	Cost II Other desidence and the	Authorities and a state of the state of	ad any father to	and the second	there is Co. 1	not min	-h	and burden the state of	
1ys	Part II. Other significant conditions con	tributing to death but i	not resulting in the	underlying cause (given in Pert I.			ntributa to the co	
Y P	Diabetes, hyperte	ension, bra	adycardia	a	三十八十二	101	raa 2□ No	3X Probably	- Unknown
Completed b	renal failure			STATE		24a. Was a perfor			prior to on of cause
Ē							-	of death?	
	05 Manager 1			CIET			es 2k No	1 Tes	2LJ No
Be	25. Was case referred to medical examiner?	lospitel:	• 🗆		Whor	ath (Check only or			
5. To	1 ☐ Yes 2 ☐ No ☐ ☐ 27. Menner of Death	1 ☑ Inpatient 28e. Date of Injury	2 ER/Outpat	ent 3LI DOA	4LI Nursing i	Home 5 Resid			
To L	1 ☑ Natural 5 ☐ Pending	(Month, Day Y		W	ork? □Yes 2□No	255. 555510911	out out of		
Certification:	2 Accident Investigation 3 Sulcide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, ferm, Specify)			28f. Location (S City or Tow		er or Rural Route	o Number,
edical Co		ician: To the best of mer: On the basis of ex-	amination and/or						nuse(s)
completely filled in by the funeral Medical Certification: 7	29b. Signature and title of certifier	and manner state		29c, Licer	nse number		29d. Date signed	(Month, Day, Y	ear)
	900	~		1	1671	1.	1		
	- Munich			7	+911	h	may 11,	1999	
	30. Name and address of person who co				5 1		0050		
	Dennis Friedman, M. 31. Date filed (Month, Day, Year)			ove Road,	Kockvill	e, MD 2	0850		
State gistrar	JAN 13 199	32. Registrer's	Signature &	Loon	1/2/				



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 1. Decedant's Nama (First, Middla, Last) 3 Time of Death Month 1999 Lester Nash, JR. Jan. 3:15am 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Prince Georges Hospital Cheverly Prince Georges If Under 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax 8. Data of Birth (Month, Day, Year) 12 M 2□F Days Hours Vre 724-22-2059 72 Oct. 26, 1926 Virginia Usuel Residence of Decedent 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 ☐ Yas 20No Prince Georges Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda U.S.A 9405 Hickory Park St. 20743 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Navar Married 2 Married 1) Yas 2 □ No If Yas, Giva unknown Yaar or Dalas: 1 ☐ Yas 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Garage Man Rental Car 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Lester C. Nash, Sr. Lillian Thomas 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Mary F. Nash / Wife 9405 Hickory Park St., Capitol Heights, Md. 20743 20b. Place of Disposition (Neme of camatary, crametory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Quantico National Cem. 1/12/99 Triangle, Va. 22. Nama and Addrass of Facility Ames Funeral Home, Inc. 8914 Quarry Rd. Manassas, Va. 20110 23a. I art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Causa (Final es disaesa or condition rasulting in death) Dua to (or as a consaquenca of) Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaasa or Injury monar thet Initieted avants rasulting in daeth) Last Dua to (or as a consequence of): matolo 23h. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ner 24b. Wara autopsy findings available prior to complation of cause of death? 24e. Was an autopsy performed? 2 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) axaminar?
1 Yas 2 No
27. Mannar of Death Hospitat: 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how Injury occurred 5 Pending invastigation 1 ☐ Yas 2 ☐ No 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 6 ☐ Could not be 28e. Placa of Injury - At home, farm, straet, factory, offica building, atc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, data and placa, and dua to the ceuse(s) and mannar es steled.

Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mannar stated. 29b. Signature and title of 29c. Licansa number 29d. Data signad (Month, Day, Year) m 30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) Ashb Ave #223, Bowle, MD

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a, State

11. Marital Status

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Director

Funeral

by

Completed

Funeral

Director

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Certification:

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Box 68760.

Division of Vital Records,

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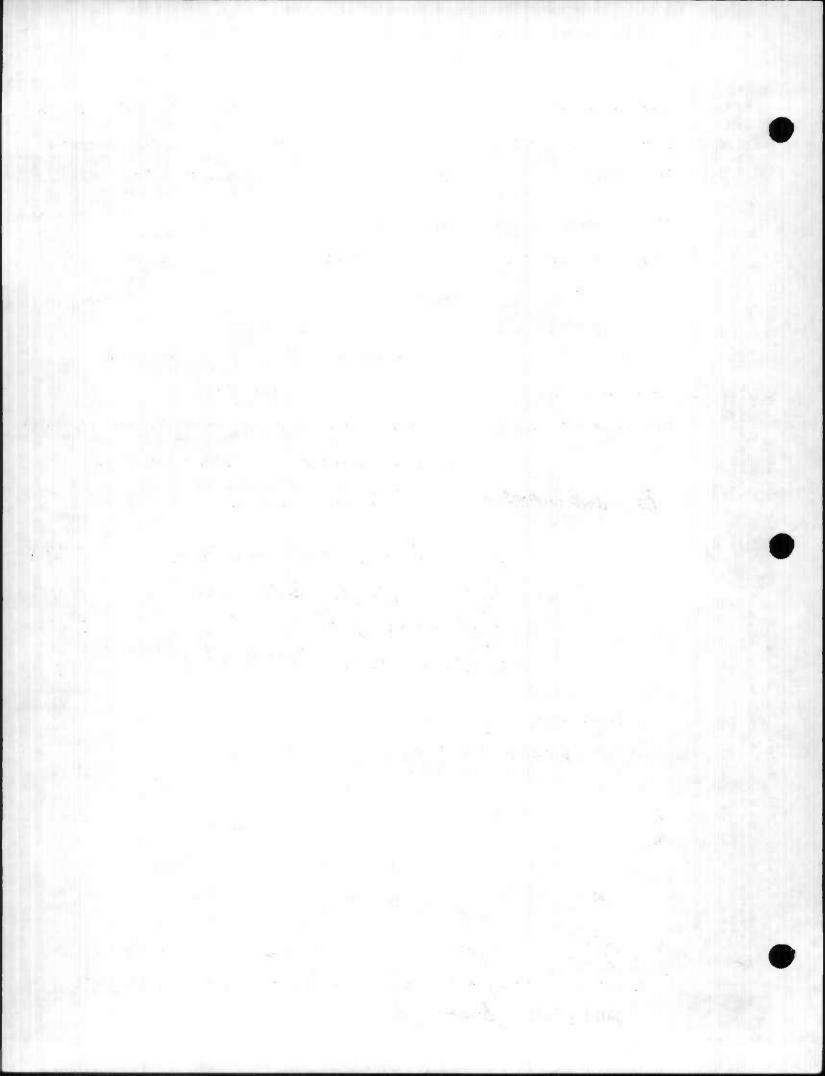
29a. Certifier

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32/Registrar's Signatura

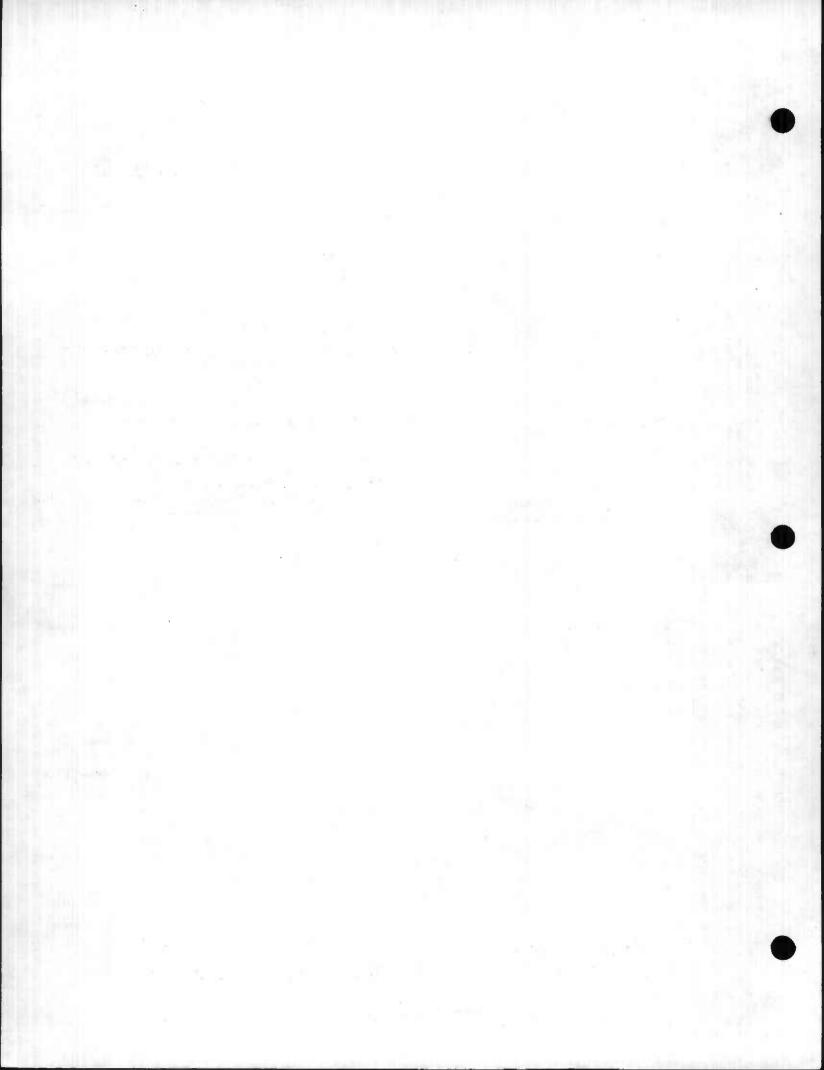
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State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Re	g. No. 9 9	01624
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Physic /Med		SONNY	T. NGUYEN			JANUARY	7, 1999	1625 PM
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Funera Director		5. Social Security Number 6. S 634-28-4252 Usuel Residence of Decedent	Sex 7. Age (In yrs. las	st birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, NOVEMBER		Birthplace (State or Foreign Country) VIETNAM
yland		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
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Man and and and and and and and and and a			7	10f. Zip Code	0.0		g. Citizen of Whet	
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21215-0020 within 72 hours after sens. Than "netural", or the the Medical Exemple	by	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cub 1 ☐ Yes 2 No		Rican, etc.)	Specify:	/hite, etc. ASIAN
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The state of the s	F	19e. Informent's Neme/Relationship (Type, Print)	19b. Mailing Address (Street			City or Town, Stell	le, Zip Code)
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mit. ports		21. Signeture of Funerel Service Lice		22. Name and Addre	ess of Facility			
20558		Century	S. Di Mus =	HINES-RIN			-	NG, MD 20904
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/ /Medical Examiner	ы	Immediate Cause (Final disease or condition resulting in death)	· Multipl	& Stab No	rund			1
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r VITAL Prescion: The scentificate director, peg	Be	25. Wes case referred to medical examiner?			26. Place of Deet	h (Check only one	9)	
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To the Hospital or within 24 hours after To the Funeral Direction completely filled in	edical	(Check only Medical Examone)	ysician: To the best of my knowled niner: On the basis of examination and manner steted.	n and/or investigation, in my o	odinion, deeth occurr	red at the time, da	te and place, and	due to the cause(s)
To th To th comp	M	29b. Signeture end title of certifier		29c. Licens	se number		d. Data signed (M	a to a second
7-		Derwin JCh	ufe m	O	ME	JA	ANUARY 8,	1999
2		30. Name and address of son who Dennis J. C	completed cause of death (Item 2 hute, mo 111	3a) (Type, Print) Penn Street,	Baltimore	e, Maryla	and 2120	
St Regist	ate rar	31. Dete filed (Month, Day, Year)	32. Registrar's Signatur	B. Sport	W			

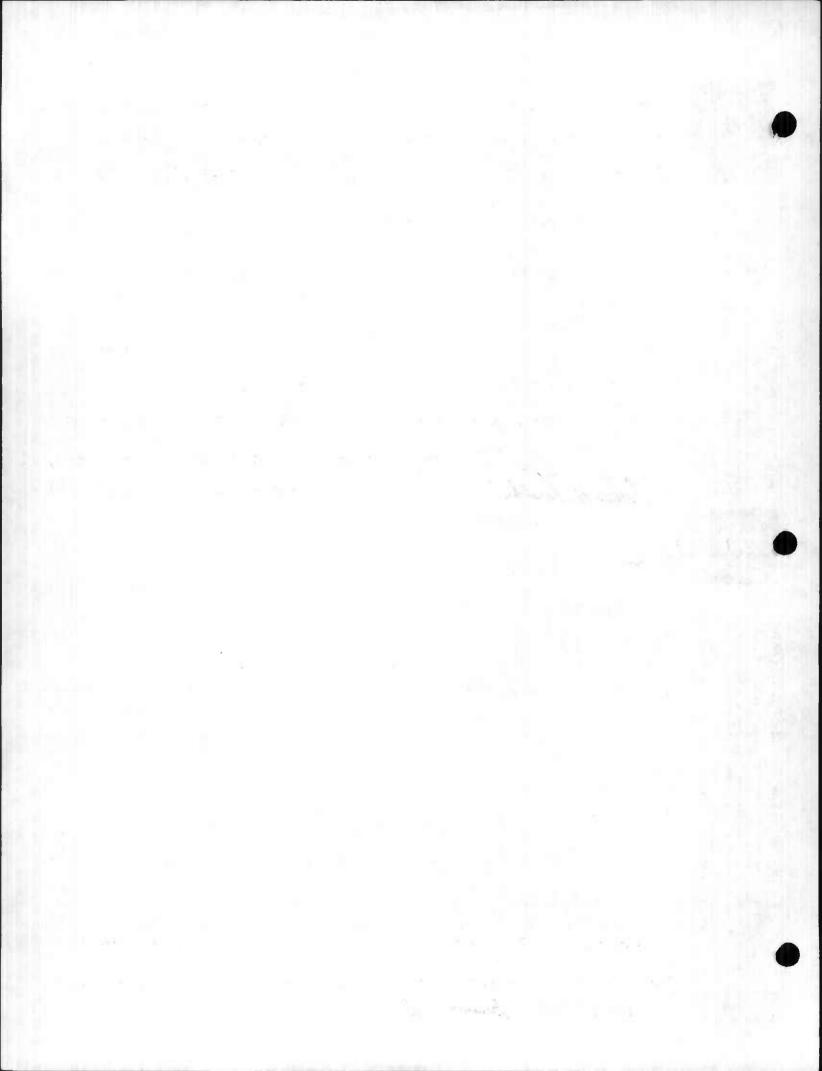
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Yaar 1:20 PM RUSSELL GORDON NORRIS 3,_ Jan. 1999 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Genesis Eldercare- Meridian of Queen Anne's Centreville Corsica Hills
5. Social Sacurity Number 6. Sax If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) 213-09-1491 MM 2□F Months Days July 16,1911 Maryland Usual Rasidance of Decedant 10c. City. Town or Location 10a. Stata 10b. County 10d. Inside City Limits Queen Anne's Centreville 1 Xes 2 □ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21617 U.S.A. 115 Wharf Lane Was Decedant of Hispanic Orlgin? (Specify Yas or No-It Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status 12. Was Decedant Evar in U,S. Armed Forcas? Black, Whita, atc. 1 Yas 2 No If Yes, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White XXWidowad 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Dacedant's Education (Specify only highast grada complated) Bethlehem Steel Elamantary/Secondary (0-12) Collega (1-4or 5+) Foreman 18. Mothar's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Florence Lookingland Emory Norris 19b. Meiling Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Son G. Norris, 105 Wharf Lane, Centreville, Md. 21617 Robert 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) Jan. 8, 20a. Mathod of Disposition 20c. Locetion - City or Town, Stata 9 9 9 N Burial 2 □ Cramation 3 □ Ramoval from Stata
4 □ Donation 5 □ Other (Specify) Chesterfield Cemetery Centreville, Md. 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Hor 408 S. Liberty St., Centreville, Md.

Approximate Interval Between Onset and Death Ischemic Cordcompopatty Immediate Cause (Finel disaasa or condition rasulting In death) Gronon Arten Siseane Saquantially list conditions, if any, leading to immadiata ceusa. Enter Underlying Cause (Disaase or Injury that initieted events rasulting in daath) Last Dua to (or as a consequence ot) Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Chronic Obstructive Almoren 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of death? 24e. Was an autopsy performad? Caucona pulersion 1 Yas 2 No 1 Yas 2 No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 28a. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding Investigation 1 Yas 2 No

Physician /Medical **Examiner** death certificate be axecuted physician and the burial-transit P.O. Box 68760.

Department of Important: If any injury or

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or itema 23a or 28a-f show ury or other traumatic svent, the Medical Examines must be notified at

Baltimore, Maryland 21215-0020

Examiner Physician/Medical as t 950 signed by the a þ Completed page 2 Be 10 funeral After t s after death

Division of Vital Records.

Hospital or Attending

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25. Wes cese letarrad to madicel axaminar?

1 Yas 2 No 27. Mannar of Death

1 Natural 2 Accident 3 ☐ Suicida

4 Homlelda 29a. Certifier (Check only one) 2 Medical Examinar: On the basis of axamination and/or invastigetion, in my opinion, daeth occurred et the time, date and place, and dua to the ceusa(s) and mannar stated.

6 Could not be detarmined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Depens

281, Location (Streat and Number or Rural Routa Number, City or Town, Stata) 112 Certifying Phyaician: To the best of my knowledge, death occurred at the time, data and place, and dua to tha causa(s) end menner es steted.

29b. Signature and titla of certitian

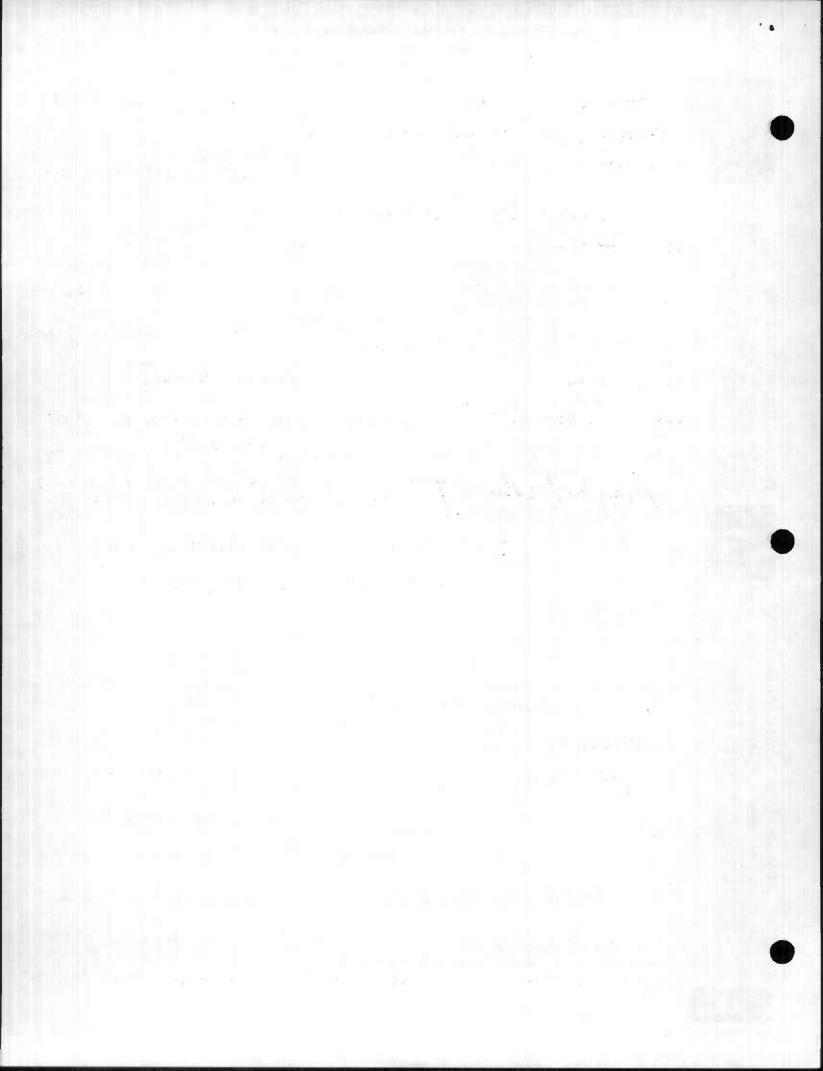
29c. Licansa number H - 42587 29d. Date signed (Month, Day, Year) Jan. 4, 1999

30. Name and addrass of person who completed ceuse of death (Itam 23a) (Type, Print)

JAN 0 5 1999

Russell Schilling, M.D.; 2540 Centreville Rd., Centreville, Md. 21617 31. Data filad (Month, Day, Year) 32. Registrar's Signatura

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JANUARY **Physician** WILLIAM EDWARD NOLAN 2, 1999 9:05 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick
| H Under 1 Year | H Under 24 Hrs. | Frederick Memorial Hospital Frederick 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dev. Yeer) Birthplece (State or Foreign Country) **Funeral** Deys 10 M 2□ F Months Hours Min. Yrs. Director 578-07-7299 78 May 22, 1920 Washington, DC Usual Residence of Decedent death with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits h end Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, it a Medical Expiriner inset be notified as 1 Yes 2 No Director Maryland Frederick Walkersville 10g. Citizen of What Country? 10e. Street end Number 10f Zin Code 104 Albany Ave., East 21793 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other traumetic avent, it a Medical Essimenance. 1 ☐ Yes 2 🗓 No If Yes, Give Yaar or Detas: 1 Never Married 2 Merried 1 Yes 2 No à 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Law Enforcement Captain 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) John Hampton Nolan Edna Marie Staunton 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) 104 Albany Ave., East, Walkersville, MD 21793 Emilie Nolan, wife 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 1/6/99 4 ☐ Donetion 5 ☐ Other (Specify) Resthaven Memorial Gardens Frederick, Maryland 21. Signeture of Funerel Service Licensee 22. Nama end Address of Fecility Stauffer Funeral Home 23a. Pert1. En ir the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or eart failure. List only one cause of peech line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximete Intervel Between Onset end Death Physician Immediate Cause (Finel disaese or condition resulting in deeth) /Medical ('ARDIAC Examiner INFARCTION (PROBABLE) Examiner ACUTE LYOCARDIAL

Due to (pr es e consequence of): attending physician and for use es the burial-transit The lew requires that the death certificete be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest ARRAIUSCURROTIC CARDO VASCULAR DISEASE Physician/Medicai signed by the a P.O. Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown e BONE METASTASES CANCER þ 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? been si Completed 24e. Wes en eutopsy performed? cartificata has b page 1 Yes 2 No 1 □ Yes 2 □ No Physician: 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 SER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this Aftar this 28e. Dete of Injury (Month, Dey Year) 27. Meaner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? Certification: or Attending 5 Pending Investigation s efter death.

I Director: Aft
od in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, fectory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours eff To the Funeral Di complataly filled in **Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner steted. edicai 29a. Certifiar (Check only 29b. Signatura and titla of certifier 29c. Licensa number 010587 Gura 10. FREDERCK Itasp MAKORIAN 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) VICE PLES NED AFFAIN MO. FREDERICE MARTLAND 1. STITH

State Registra

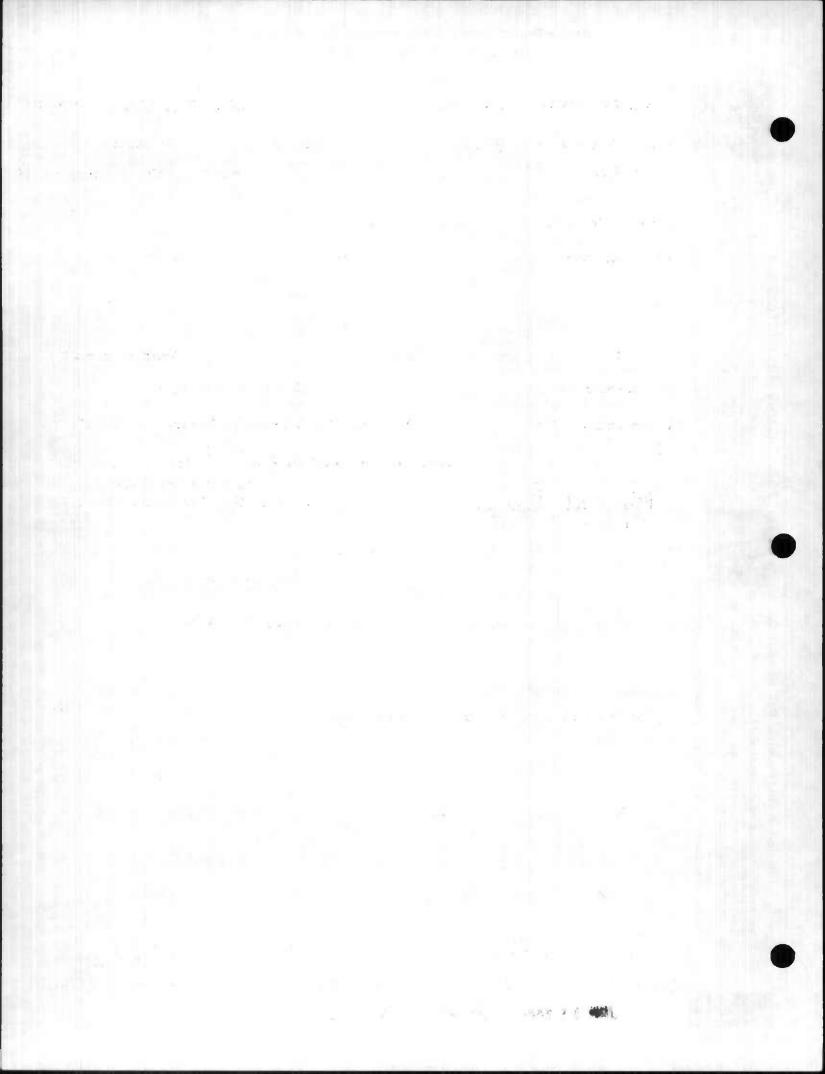
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31. Dete filed (Month, Day, Year)

JAN 0 5 1999

32. Registrer's Signeture

Gener



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dafa of Death Month DNEILL 11 , 1999 4c. County of Death AMES)ANWARY 4a. Facility Name (If not institution, give straet and number) 4b. City, Town, or Location of Death 4a. Facility Name (IT NOT ATSIMULAND MEDICAL SYSTEM DALTTIME)

VINIVERSITY OF MARYLAND MEDICAL SYSTEM DALTTIME;

To Sal Table (In yrs. last billinday) If Under 1 Year It Under 24 Hrs.

Months Days Hours Min. BALTIMORE 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) May 26, 1965 Birthplaca (Stata or Foreign Country) **X**M 2□ F 219-76-4902 Yrs. 33 Chestertown, MD Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Queen Anne's Chestertown 10e. Streef end Numbar 10f. Zip Coda 10g. Cifizen of What Country? 136 Windy Maples Lane 21620 USA 12. Was Decedenf Ever in U,S. Armed Forces? NXYas 2 □ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. XXNever Married 2 Married 1 Yas 200 No White 3 ☐ Widowed 4 ☐ Divorced Specify: 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Farmer Agriculture 17. Father's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) James O'Neill Lucinda Jackson 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) James A. O'Neil/Father 136 Windy Maples Lane, Chestertown, MD 21620 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 N Burial 2 □ Cremation 3 □ Removel from Stata 4 □ Donation 5 □ Ofher (Specify) Church Hill Cemetery 1/16/99 Church Hill, MD 21. Signeture of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, MD 21620

23a. Part. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onset end Daath Immediata Causa (Final disaasa or condition rasulting in daath) 60 days PNEUMONIA Dua to (or as a consaguanca of): Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Causa (Disaasa or Injury that Initiated avants resulting In daath) Lasf Dua to (or as a consequence of): Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings evallebla prior to complation of causa of daath? 24e. Was en eutopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Placa of Daath (Check only ona)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

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Funeral

Director

28a-f show must be notified at

0 items 23a

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"natural",

filed within 7 Hygiene.

Pages 1 end 2 should be filed nent of Health end Mental Hygis nt: If Item 27 is marked other

or other tra

permit. Page Department o Important: If any injury or

traumatic event, the Medical Examiner

Directo

Funeral

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Completed

Be

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

Hospital or Attending Physician: 24 hours efter death.

Examiner Physician/Medical by

1 Natural

2 Accidant

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physician end the buriel-tran for use as 2 signed to Completed peen hes Be Certification: To funeral After Director: / To the Hospital or within 24 hours eff To the Funeral DI completely filled in

25. Was casa rafarrad to madical axaminar? Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 27. Mannar of Daath

Hospital: 1 Inpatiant 2 EP/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of

28c. Injury at Work? 1 TYas 2 No 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how injury occurred

1 Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature and title of

5 Panding Invastigation

6 Could not be datarminad

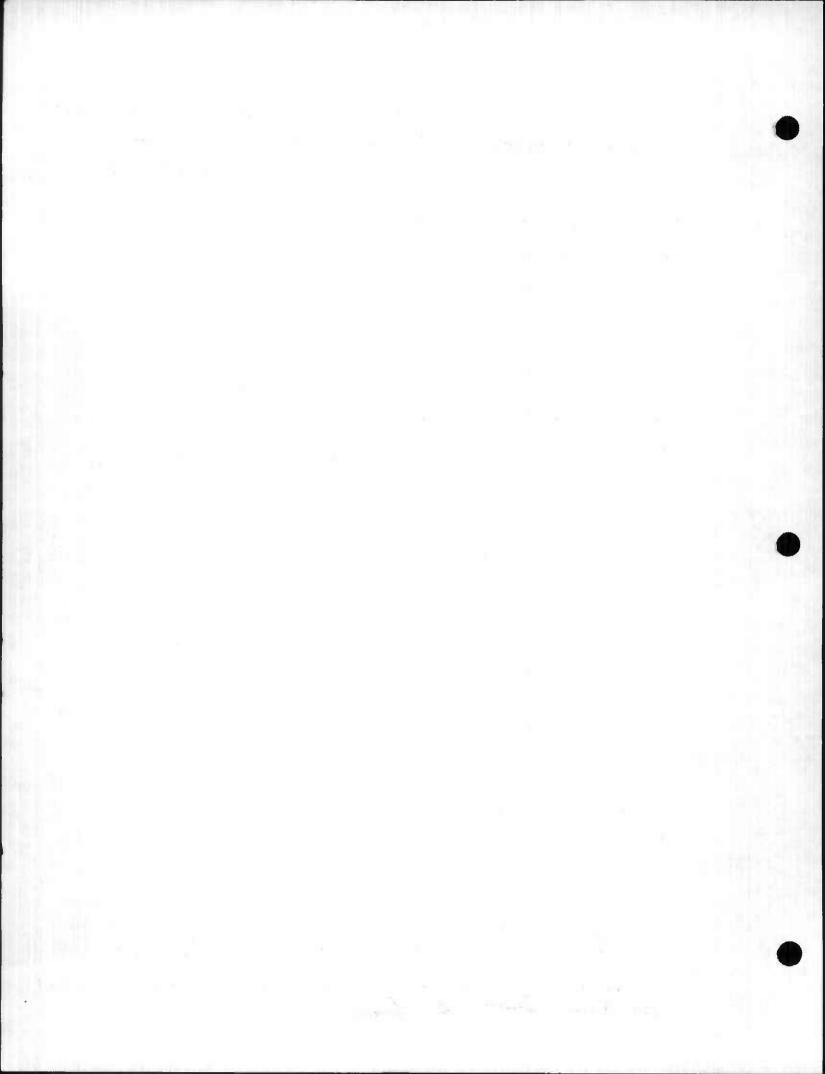
29c. Licansa numbar

29d. Date signed (Month, Day, Year) JANUARY 11, 1999

and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

1999

22 SOUTH GREENE STREET BALTIMORE, MARYLAND 21201



							Certific	ate of	Death		Reg. No.		
hysician	Decedent's Na	me (First, Mide	dle, Last)							2. Date of De Month	Dey	Year	3. Time of Death
/Medical	Polly 4a Facility Name	Foo		treet and nu		Donog	hue		4b. City, Town, or I	Januar	-		9:50pm
xaminer	3916 Virgilia Street Chevy Chase										Montg		v
neral	5. Social Security		6. Sex	Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 H							-		place (State or Foreigntry)
ctor	579-60-9 Usuel Residence		10	Months Days Hours Min. (Month, Day, Year) August 8,1911							Was	shington I	
Be Completed by Funeral Director	10a. State	10b. Count	ty	10c. City, Town or Location									Od. Inside City Limit
tor	MD	Montg	omer	Chevy Chase									1 ☐ Yes 2 ₩N
i Director	10e. Street and N 3916 Vir		Stre	et			10f. 2			10g. Citizen of Whet Country? U.S.A.			
by Funeral	11. Marital Status 1 Never Ma	44	rried	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			If Yes,	ecedent of lispecify Cub	Hispanic Origin? (Speen, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Bla	ce - Americk, White,	
pet		15. Decede	ent's Educ	etion	-100.	16a.	Decedent's U	Jsual Occu	pation	4-1	16b. Kind of B	usiness/In	dustry
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Be	17. Father's Name		e, Last)						18. Mother's Nan		, Meiden Sumen	ne)	
2	John A.		anhle (Tou	- Driett		104	Mattine Add	(Ctuan	Lois Dy		City of Town	Ctata 7	Codel
	Daniel V				sband				etend Number or Ru a St. Che				0000
	20a. Method of Di					b. Place of	Disposition (Neme of		Dete	20c. Location		own, State
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-60	Part II. Other sign	ificant condit	tions cont	ributing to d	eath but not	resulting In	the underlyi	ng ceuse g	iven in Pert I.	23b. Did	tobacco usa co	entribute t	o the cause of deat
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State Registrar

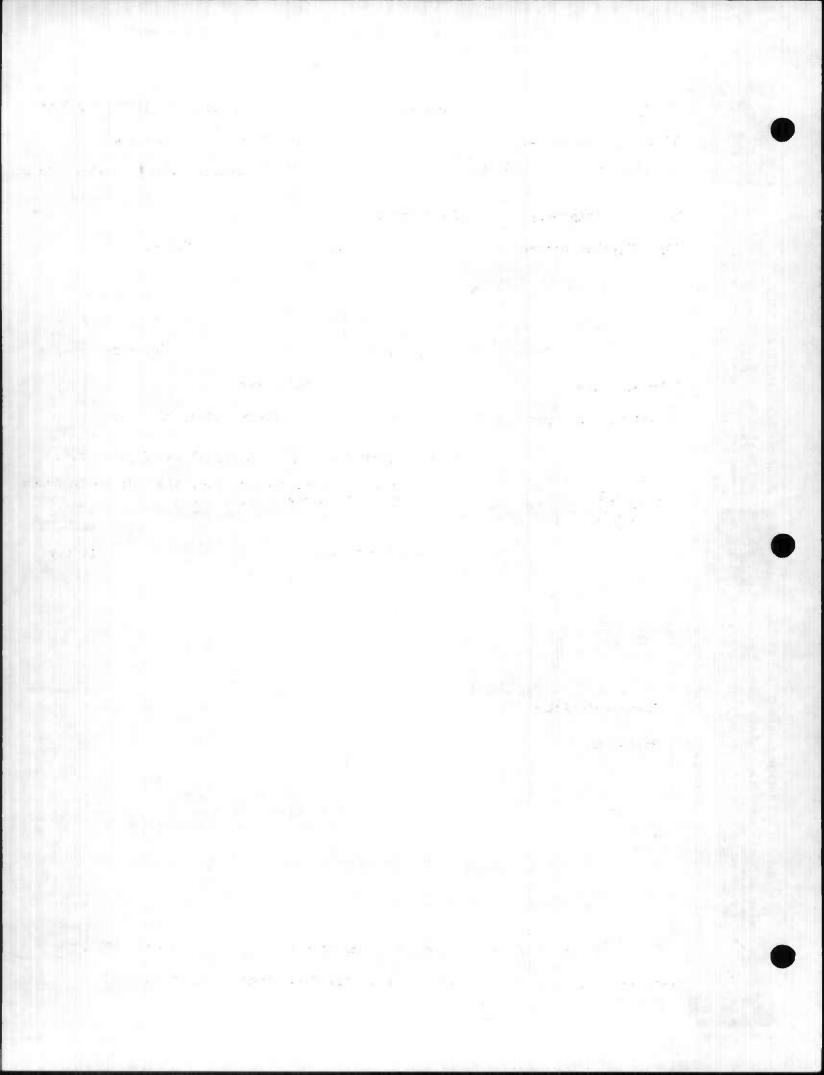
Kevin Nealon, M.D. 31. Date filed (Month, Day, Year) JAN 12 1999

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print)

5530 Wisconsin Ave. #925 Chevy Chase, Md. 20815-4330

MD D23127

January 10, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month AM JUDY ANN OTT **JANUARY** 4, 1999 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 16167 KELABAUGH RD. THURMONT FREDERICK If Undar 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplace (Steta or Foreign Country) 8. Data of Birth (Month, Dey, Year) Deys Months 215-42-3848 54 27, 1944 GETTYSBURG.PA. Usual Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No FREDERICK THURMONT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16167 KELABAUGH RD. 21788 U. S. A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Detas: 14. Rece - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yas 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) CARROLL C. TOPPER GLADYS KELLY 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Addresa (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) WILLIAM JOSEPH OTT, JR. 16167 Kelabaugh Rd., Thurmont, MD 21788 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1X Buriai 2 Cremetion 3 Ramovai from State 4 ☐ Donation 5 ☐ Othar (Specify) JOSEPH'S NEW ST. 1/8/99 EMMITSBURG, MD. 21727 21, Signature of Fuheral Sarvice Licenses 22. Neme end Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727 T. Enter the disaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiretory arrest, or haart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediete Causa (Final disease or condition resulting In death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last Due to (or as a cond Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? MOY 10 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 N Rasidance 8 Othar (Specify) 1 Yes 2♥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Haalth a Important: If Nem 27 is any injury or other trace

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

2

Examiner

Physician/Medical

b

Completed

Be

10

Certification:

edical

2 Accident

3 ☐ Suicida

29a. Certifier

4 Homicide

(Check only one)

MD

Funeral

Director

7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at

2 should be filled within 72 hours after on and Mental Hygiena.

Is marked other than "naturel", or files

Saltimore, Maryland 21215-0020

with the Maryland

death

physician and the burial-transit usa as the attending for signed by ata has been signe paga 2 should be

Box 68760,

P.O.

Division of Vital Records,

this funeral Aftar Attending I or Attending after death. I Director: Aft the 3 24 hours a Funerel D

Pert fl. Other significant conditions contributing to death but net resulting in the underlying cause given in Part I.

28a. Deta of injury (Month, Dey Year) 27. Manner of Death 28b. Time of 1 Neturel

5 Pending invastigation 6 Could not be datarmined

28a. Placa of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, daath occurred at the fime, data and piace, and due to the cause(s) end mennar ateted. 29c. Licansa number

29b. Signeture and title of continue

18 705 29d. Data signed (Month. Day, Year) 5 JANUARY 1999

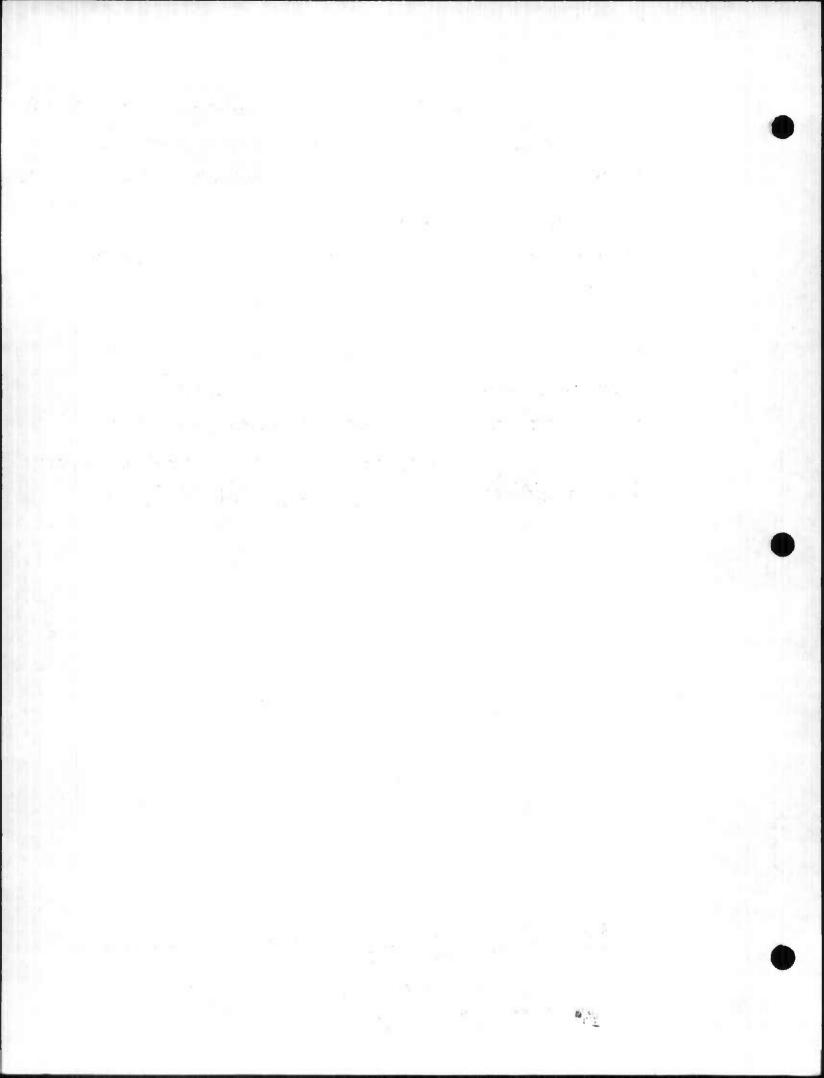
30. Nema and addrass of person who complated causa of daath (Item 23a) (Type, Print)

1999

ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, M D 21727 31. Dete filed (Month, Day, 32. Registrent Signature

State Registrar

To the Hosp within 24 hor To the Fune complately fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** O'NEAL HURLEY I.TI.I.TAN January 12 1999 1:20 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Apr. 16, 1919 9. Birthplece (State or Foreign County)
Maryland If Undar 1 Yaar 7. Age (In yrs. lest birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2DAE Months Deys 79 217-10-8653 Yrs. Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. fnside City Limits Salisbury TEXES 2 No Wicomico Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? "natural", or itema 23a or idical Examiner must be o 21801 900 Booth St. U.S.A. Funeral 14. Rece - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Yes __2/1 No If Yes, Give Yaar or Dates: 1 Never Married 2 Married 1□ Yes 25 No Specify: white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) own home homemaker 11 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Todd permit. Pages 1 and 2 should be Department of Health and Mental Missle Hurley William, Luther 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 205 Louise Ave., Salisbury MD 21804 Martha H. Reynolds-sister 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State TO Burial 2 Cremetion 3 Removel from Stata
4 Donation 5 Other (Specify) 1/15/99 Cambridge Maryland Green Lawn Cemetery 22. Nama and Addrass of Facility Thomas Funeral Home PA 21. Signature of Funeral Service Licenses 700 Locust St. Cambridge MD 21613 23a. Part1. Entar tha disease, or complications thet cause of the death. Do not enter the mode of dying, such es cerdiac or raspiratory errest, shock, or heart failure. List only one cause on each kine. Approximate thterval Between Onsat and Death **Physician** Unyocapaiol, v/anct-Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner honan The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part f. 23b. Did tobacco use contribute to the cause of death? DIAbely aclliers 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown À asthing. 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy certificate has b confestive Hearth Failone 1 ☐ Yes 2 XNo 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2₺ No 28c. Injury et Work? Certification: 27. Manner of Deeth 28b. Time of 1 Netural
2 ☐ Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide The certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner es stated.

2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and manner stated. 29a. Certifier edical

Division of Vital Records. P.O. Box 68760.

Hospital or Attending Physician: 24 hours after death. To the Hospital within 24 hours a To the Funeral Completely filled

Registrar

JAN 13 1999

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

29b. Signature and title of certifier

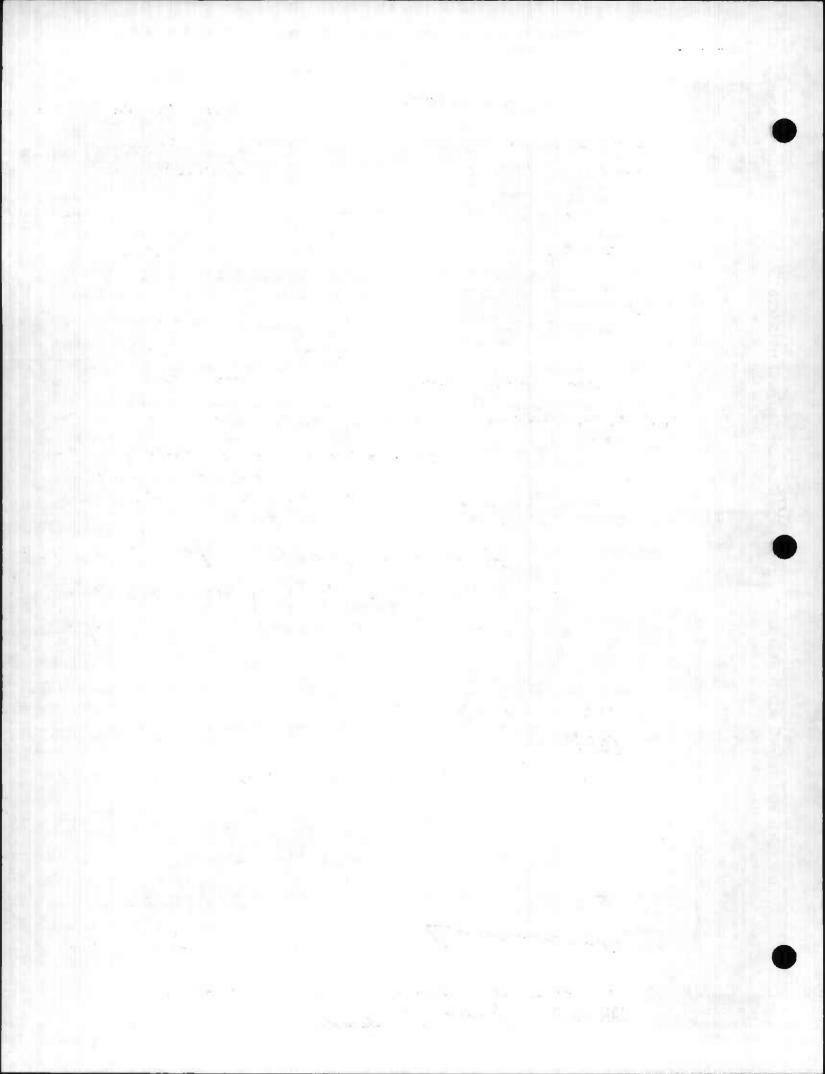
Federico G. Arthes, MD 1622A Ocean Pines
31. Date filed (Month, Dey, Year) 32. Degistrar's Signeture

Berlin, MD 21811

29d. Date signed (Month, Day, Year)

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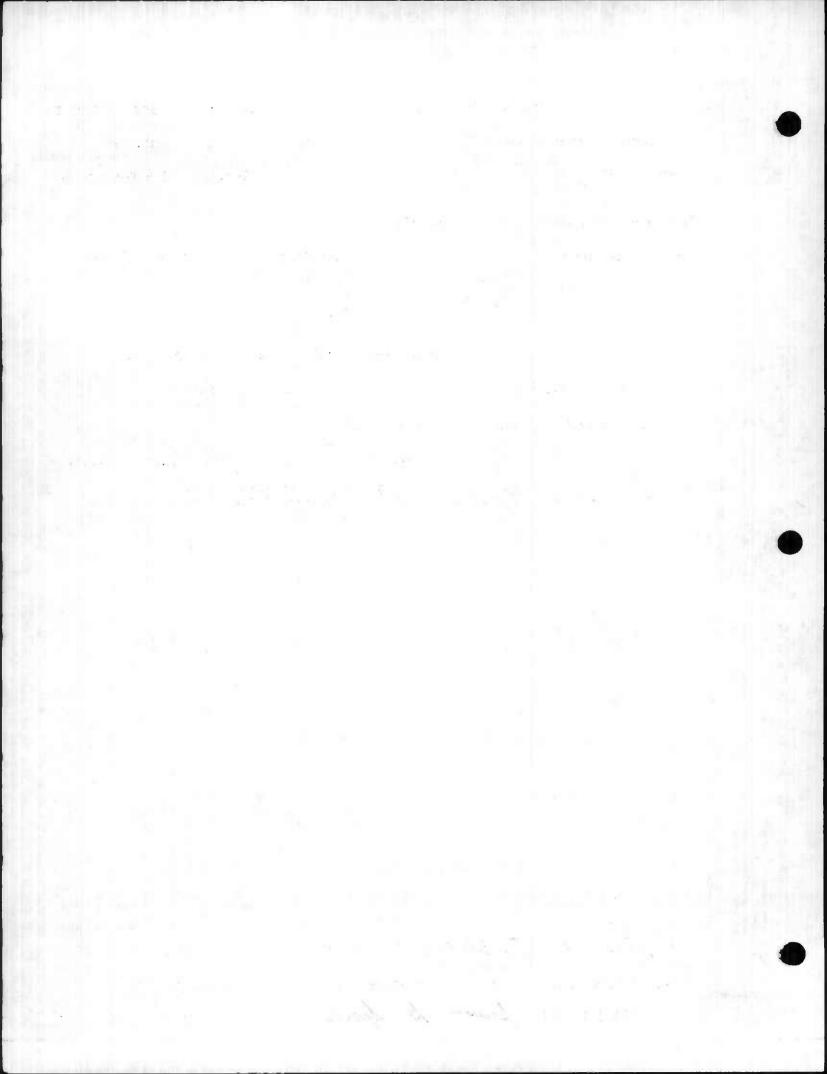
29c. Licansa number



State of Maryland / Department of Health and Mental Hygiene 99 01632

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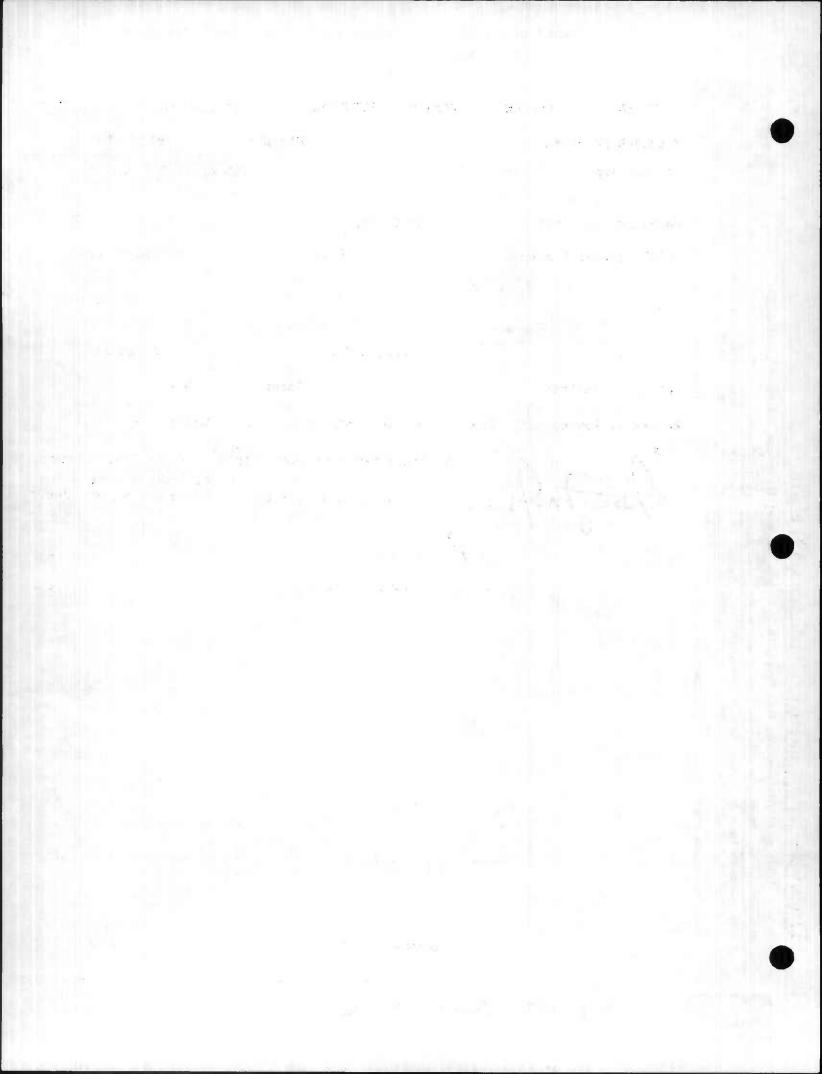
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State of Maryland / Department of Health and Mental Hygiene 9

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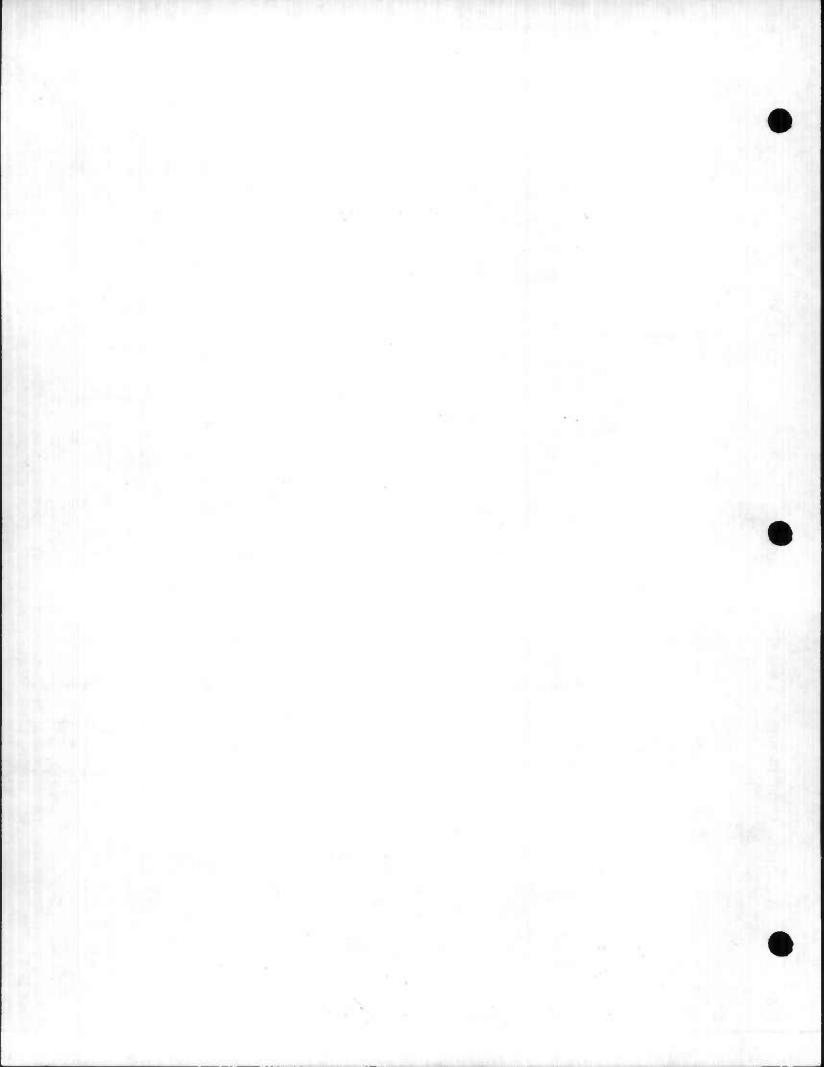


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** January 10,1999 Agnes A. Pierro 7:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health @ Circle Manor Kensington Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F Yrs. 044-01-2382 89 Aug. 15, 1909 Director Lithuania Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hyglene. Important: if Nem 27 is marked other than "naturel", or Nems 23s or 28s4 show any injury or other traumatic event, the Medical Examinat Injury by notified as 1 ☐ Yes 2 TNo Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Williamsburg Drive 20901 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2K No Specify: à White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B John Achumback 2 Anna Ripinski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Pierro (daughter) 111 Williamsburg Drive, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/12/99 Alexandria, Virginia Francis J. Collins Funeral 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Home, Inc. 500 University Blvd. West Silver Spring, MD 20901 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Betw Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical neumonia Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) the state # atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by 1 Yes 2 ANo 3 Probably 4 Unknown þ 90 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 000 ecad 1 Yes 28YNo 1 □ Yes 2 □ No certificate Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ANursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2No To this 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) Ahser 1 Natural 2 Accident Athending 5 Pending death. 1 Yes 2 No investigation after death Director: 6 Could not be 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D completely filled it Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Gate signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 34032 0 d address of person who death (ttem 23a) (Type, Print) RRAGUT AVE KENSINGTON, 720 31. Vate filed (Month, Day, Year, 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



					State	of Ma	ryland				Health and <i>Death</i>	l Me			99		116	35
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	24 Land 2		19a. Informant's Neme/Relations's JOSEPH PINCUS/S	ON ON	oe, Print)			19b. Meilin 9120	g Address DONNA	(Street	AN DRIVI	Rural i	Route Numbe SPRING	er, City o	D,	Stete, 2	Cip Code)	22153
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	/Medical Examiner		Immediate Cause (Finet disease or condition resulting in death)	a		esp	DU O (or a	RUN s a conseq	uence of):	rec.	Moor	_			-	8	291	7
	2 #	i e		- h	Ce	rele	O Va	rul.	or a	CC	eleco	2					1 cm	
,00	physician and the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				ue to (or a					1						
Box 68760,	death certificate be assout e attending physician and id for use as the burial-trar	•	Cause (Disease or Injury that initiated events resulting in death) Last			D	ue to (or as	a consequ	uence of):							1		
O. B	y the atte	Physician/M	Part II. Other significant condition	ns con	tributing to	death but	not resultin	ng in the ur	nderlying ce	use gi	ven in Part I.		23b. Did t	lobacco	use con	itribute	to the ca	use of death?
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9	aw requir	Completed						16					24a. Was perfo	an autop med?	osy	, 3	Were auto available p completion of death?	psy findings rior to n of cause
- f	s cartificata hi director, paga	S											101	res 2	BNO		1 🗆 Yes	20 No
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	ar death. rector: After this c by the funeral dir	tification:	1 ☐ Raturat 5 ☐ Pending investig	ation	28a. Date (Mo			b. Time of Injury	M		ry at rk? I Yes 2 □ No		d. Describe I					
2	The Co	듣	3 Sulcide 6 Could n 4 Homicide determi	ned	28a. Plac buik	ce of Injur	y - At home (Specify)	e, ferm, stre	eet, fectory,	office		28	f. Location (S City or Tox			er or Ri	irel Route	Number,

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Myron Lenkin MD 31. Date filed (Month, Day, Year)

JAN 1 1 1999

2309 Shorefield Rd Silver Spring Md 20902

State Registrar

Medical Certif

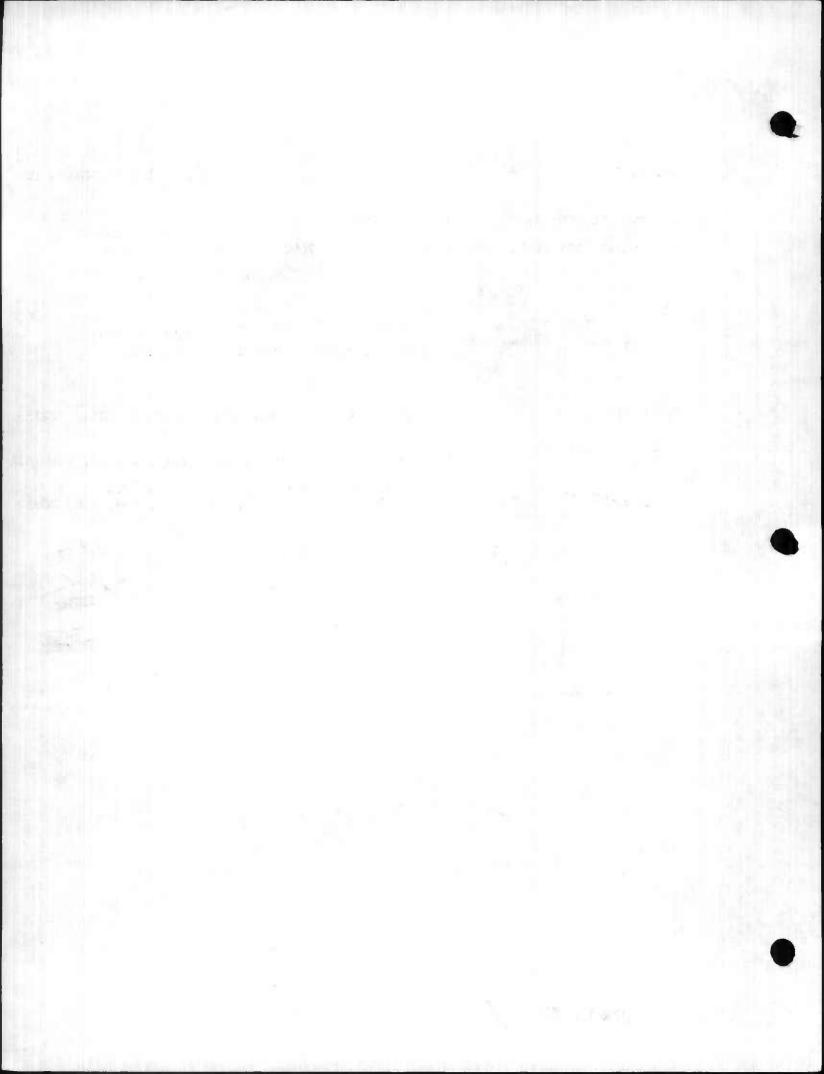
29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and manual stated.

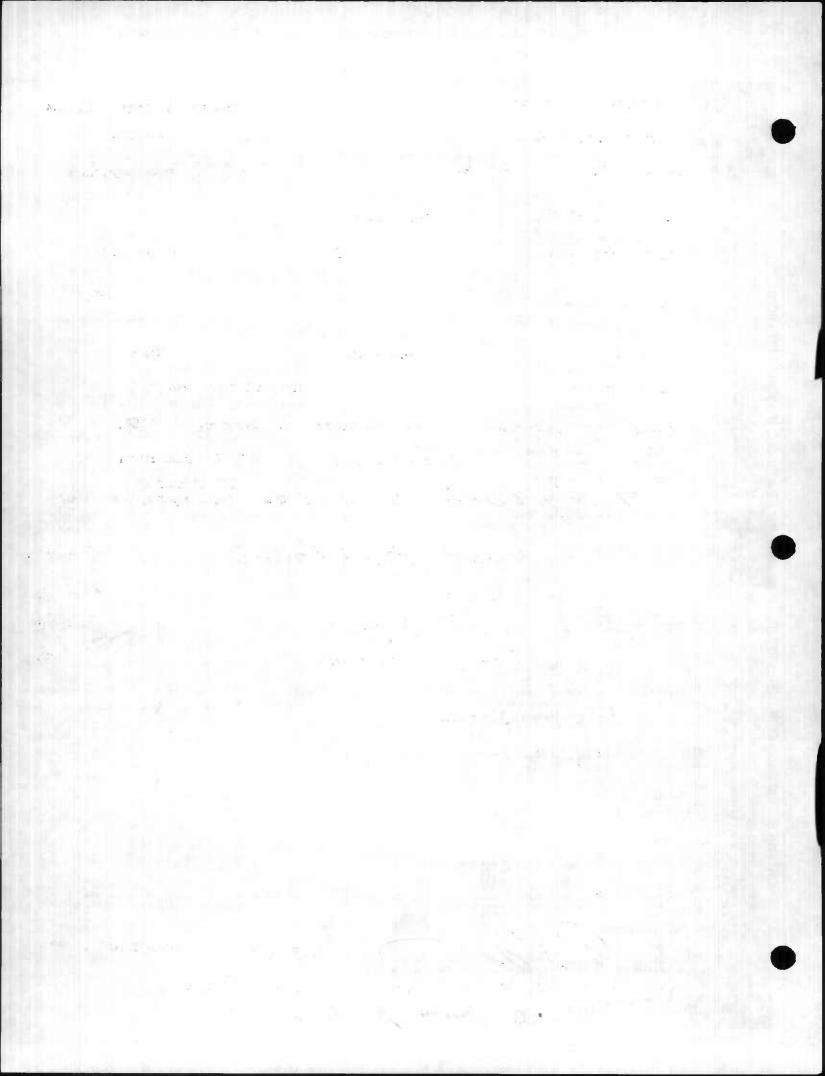
29d. Date signed (Month, Dey, Year)

Jan 6,1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Medical Examiner Sacond Specific Sacond Sp	lity Name (If no Cred He I Security Num -44-166 esidence of De Ite I Community	d 11 cedent bb. County Garrett ria Aveni 2 Married Divorced Decedent's Edenly highast grad ry (0-12) st, Middle, Last) rris vReletionship (7 corge /	ue 12. Was Dec Armed From Yas If Yes, Giragaror Ducation	7. Aga (In yrs. 84	yrs. ty, Town or Lo Bloomir 1.5. 13. v	ngton 10f. Zip Code 21523 Was Decedent of If f Yas, specify Cut 1 Yes 2 No	Hispanic Origin? (S) pan, Mexican, Pueric	8. Date of Birth (Month, Day) Jan • 9,	4c. County of Alleg Alleg 1914 Og. Citizen of W United	of Death any 9. Birthplaca Country) Maryla 10d. 1 What Country? States a - American lik, White, etc.	inside City Limits
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hysician /Medical xaminer Dear Lisuary Lisu			Ramoval from	State 20b. I	Plece of Dispo cemetery, crem	Bittinge esition (Name of matory or other pla emetery	ace)	Dete	20c. Location -	City or Town,	
hysician /Medical xaminer Jeguna Lisuari, la superior disease resulting X Sequenti fi any, le cause. Cause (Cause)	21. Signature of Funaral Service Licensaa 22. Name and Address of Facility Boal Funeral Home Westernport, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.										
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Geath y the figure 3	Accident	Pending investigation Could not be determined	28e. Place	nth, Day Year) a of Injury - At h ling, etc. (Speci	Injury come, ferm, str		Yes 2□No	er or Rural Ro	ute Number,		
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2	(of person who	completed cause	se of deeth (Iter	m 23a) (Type:/	Print)	D15463		JANUARY	ø5,	1999



State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 3, 1999 MABEL PLANITZER 8:30 A.M. ANN January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner College View Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F Yrs 033-09-4965 Feb. 20, 1905 Massachusetts Director 93 Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be nothed at 1 Yes 2 □ No Directo Maryland Frederick Walkersville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 500 Chapel Court 21793 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 20 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any Injury or other traumatic svent RRE. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Albert Heinz Matilda Flesser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jane P. Snider, daughter 20 W. Pennsylvania Avenue Walkersville, MD 21793 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Bellevue Cemetery 1/9/99 4 ☐ Donation 5 ☐ Other (Specify) Lawrence, MA 21. Signature of Funeral Servica Lidensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21793 40 Fulton Avenue Walkersville, MD Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s, or heart fall on List only one cause on each line. Approximate tnterval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last due to (or as e consequenca of): Box 68760 Physician/Medicai Due to (or es e consequence of): 98 use 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 2 No 1 Yes 3 Probably 4 Unknown م Division of Vital Records, ģ 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed peeu has page certificate or Attending Physician: director 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 1 Natural Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending death. investigation 1 Yes 2 No Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide after within 24 hours at To the Funeral D completely filled is To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner as steted.

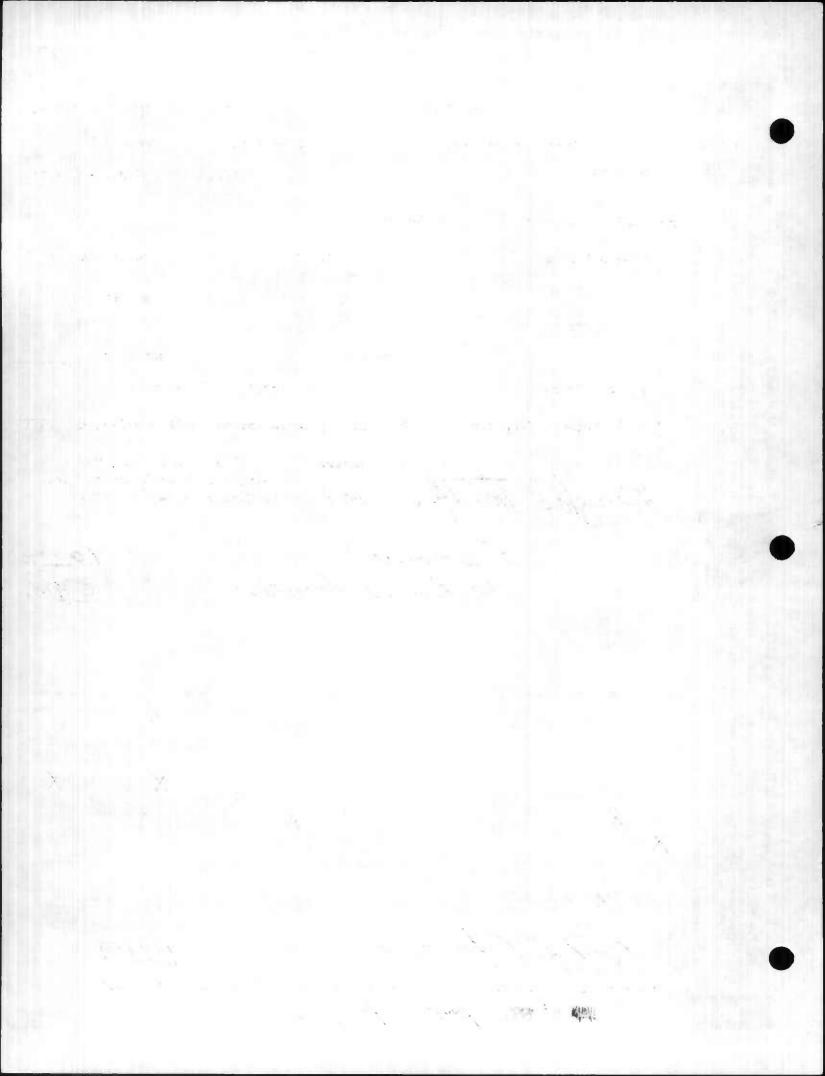
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of cook 29c. License number 29d. Date signed (Month, Day, Year) D-13971 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 W. 9th Street Robert L. Kaufmann, Frederick, Maryland 21701

32. Registra s Signature

Registrar

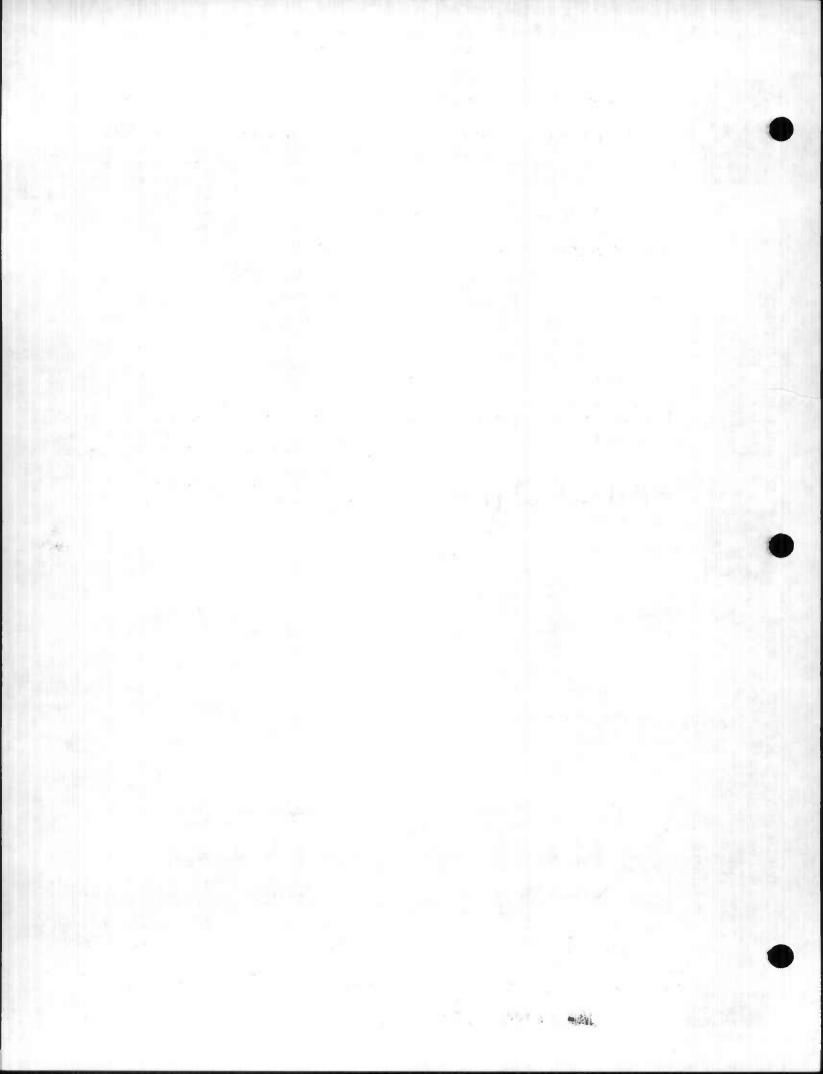
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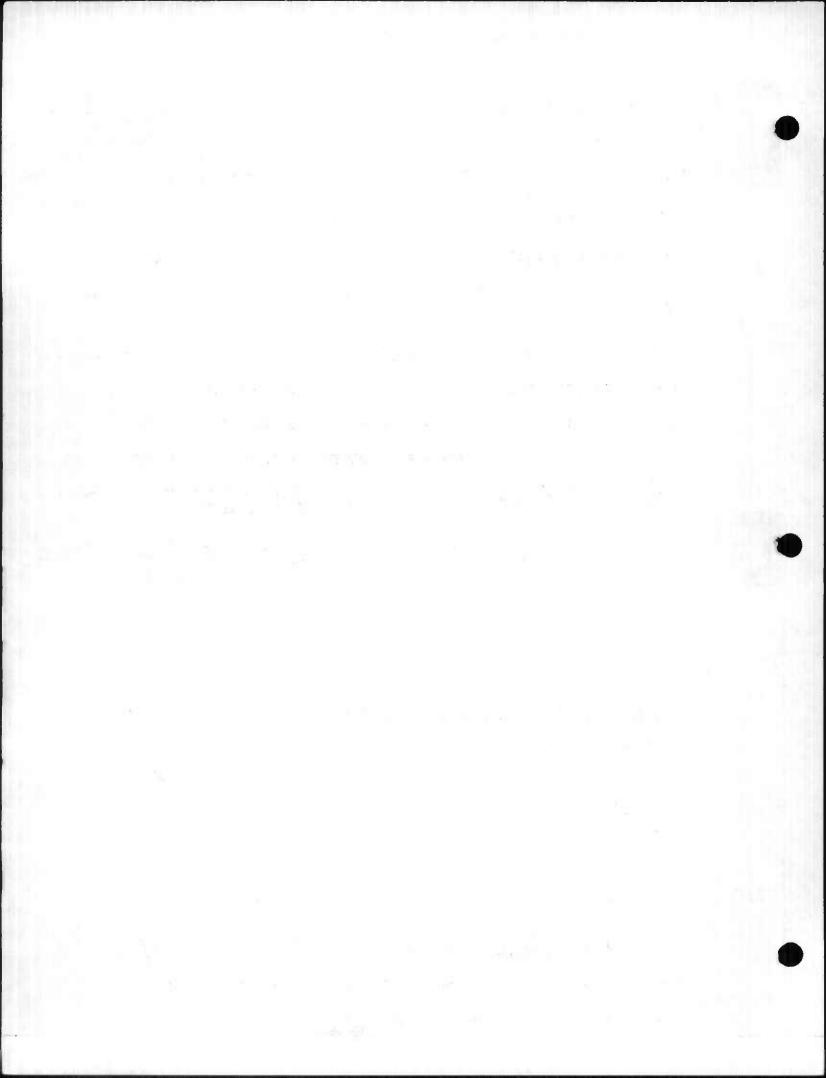


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l s	Frede 5. Sociel Security N 286-14-9 Usual Residence of 10e. State Maryland	rick Hea						4b. City, Town, or				1112 222	
	286-14-9 Usual Residence of 10e. State Maryland	779	Frederick Health Care Center Frederick Frederick										
	10e. State Maryland	Decedent	Sex 7	. Age (In yrs. 80	last birthday) Yrs.	If Unde Months	or 1 Year Deys	If Under 24 Hrs Hours Min.	8. Date of B	irth Year 1918	9. Birthpla Ohio	ce (State or Forei	
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Funeral (10e. Street and Nur 809 C S	tratfor		10f. Zip Code 21701						What Country .A.	y?		
11. Marital Status 1 □ Never Married 2 □ Married \$□\$\times \times \ti			Armed Ford 1 Yes 2 If Yes, Give	1 ☐ Yes 2X No			edent of Hecify Cube	Ilspanic Orlgin? (S an, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	Blac	e - American ck, White, et :: Whit	c.	
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	17. Fether's Nama	(First, Middle, La	st)		ROBBI			18. Mother's Na Ruth		ie, Maiden Suman	EISCHN	IAN	
	19e. Informant's Ne Stephani		y, Daught	er						ber, City or Town, erick, M			
2			☐Removal from Si	20b. F	Place of Dispo emetery, crem ithsburg	sition (Na natory or Cren	ame of other plan ntory	, January	Date 4, 1999	20c. Location - Smithsbur			
	21. Signature of Fu	meral Service Lic	ansea	M0025	5 K	eene	y an			Funeral		701	
+	23a. Part1. Enter the	he disease, or co	mplications that delivers on a	used the deat	h. Do not ent	er the mo	ast of dyir	ng, such as cardia	c or respiratory	derick,		L 701 Approximate Intervat Between	
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			b	Dua to (c	n as a conseq	dence of	,.						
	Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury c.												
Cause (Disaase or injury that initiated evants resulting in death) Last Due to (or as a consequence of):													
-	Part II. Other signif	Cant conditions	contributing to dea	th but not res	ulting In the u	nderlvina	cause oi	ven in Part I.	23b. Di	d tobacco uss co	ntributs to t	he cause of deat	
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2 2000	1 ☐ Yes 2 2 27. Mannar of Deat			patient 2 Injury Day Year)	ER/Outpatien 28b. Tima of		28c. Inju		4	sidence 6 Other			
	1 Natural 2 Accident	5 Panding investigat	ion		Injury	М	1 🗆	rk? Yes 2□No					
	3 ☐ Suicide 4 ☐ Homicide	determine	28e. Place C	of Injury - At high	ome, farm, str	eet, facto	ry, office		28f. Location City or T	(Street and Numb own, State)	oer or Rural	Houte Number,	
	29a. Cartifiar (Check only one)	1 Certifying I 2 Medical Ex	Physician: To the baseminer: On the base and manner	is of axamina	wladge, daath tion and/or Inv	occurre astigatio	d at the tie	ma, data and place opinion, daath occ	e, and due to th urred at the time	e cause(s) end ma e, date and place,	anner as sta and due to t	ted. he cause(s)	
	29b. Signature and	title of certifier	91 -		10.1	2	9c. Licens	se number		29d. Date signe	d (Month, D	ay, Year)	
	1 Ov	m 1	M	- 1	N		07	21944		Januar	y 4,	1999	
3	30. Name and addr	ess of person wh	o completed causa		n 23a) (Type,	Print)	1 1	1+1 (-	Fra	deride	MD.	ומרונ	

DHMH 16 Rsv 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month **Physician** You ELEANOR FRANCES MORGAN RICE JANUARY 12, 1999 /Medical 4:00pm4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Deeth WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Hours 82 Yrs. Director 579-34-4045 JAN. 6, 1917 WASHINGTON, DC Usuel Residence of Decedent death with the Maryland 10e Stete 10b. County 'netural', or Items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits MD TALBOT Funeral Director ST. MICHAELS 1 X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1104 HARRISON AVENUE 21663 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decadent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after ☐ Yes 2 X No f Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Be Completed by Specify: WHITE 3 ₩ Widowed 4 Divorced The Medical 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 -0-ANALYST GOVERNMENT RECORDS treumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Pages 1 and 2 should be nent of Health and Mental is marked JAMES FREDERICK MORGAN ELEANOR GORMAN 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is eny Injury or other treu once. SHEILA J. RICE 4204 54TH ST., BLADENSBURG, MD 20710-1418 20e. Method of Disposition 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State CHESAPEAKE CREMATION CTR. 1-14-99 STEVENSVILLE, MD 4 ☐ Donetion 5 ☐ Other (Specify) of Funeral Service License 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Non small cell concerflung, left /Medical Immedieta Ceuse (Finel mouth diseese or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed bunel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disaase or injury that initieted avants resulting in deeth) Lest Dua to (or es e consequença of): P.O. Box 68760, Physician/Medical for use as the Due to (or es e consequence of): Part II. Other elgnificant conditions contributing to death but not resulting in the underlying causa given in Pert i. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No Records, þ director, page 2 should be Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? certificate has 1 Yes 2 No 1 Tyes 2 No Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Death (Check only ona) exeminer's 214 No Other: 4 Nursing Home Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 5 ☐ Residenca 6 ☐ Other (Specify) After this the funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Divatural 5 Pending Invastigation deeth. 1 Yes 2 No s efter deeth 2 Accident 3 Suicide 6 Could not be datermined 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) illed in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Phyelcian: To the best of my knowledge, death occurred et the time, date end place, and due to the ceusa(s) and mannar as steted.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end place, and due to the causa(s) end mannar stated. 29a. Certifiar Medicai completely (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Date signed, (Month, Day, Year) 30. Name and address of person who completed cause of death (tam 23e) (Type, Print) WILLIAM H. WOOD, JR., M.D., 506 IDLEWILD AVENUE, EASTON, MD 21601 32. Registrer's Signeture 31. Data filed (Month, Day, Year) State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day S 8:45 PM Ethel E. Reed TANCARY 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 7442 Brandenburg Circle Sykesville Carroll County If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) April 23, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 ▼ F 66 Yrs. 1932 PA 182-24-8074 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits New Castle Wilmington 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 Echo Road 19810 U.S.A. 12. Was Decedent Ever in U,S Armed Forces? Was Decedenl of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapy Assistant Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Elizabeth K. Lorentz Ernest Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard A. Reed (son) 7442 Brandenburg Circle, Sykesville, MD 21784 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 N Burial 2 □ Cremation 3 N Removal from State Arlington Cemetery 1/14/99 Drexel Hill, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL (Box 195) uan Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause — each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) · METASTATIC TRANSITIONAL CELL CARCINO, MA = 8 MO Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of) that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE, HYPOTHYLOWISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidenca 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1- Natural

as the bunal-trans requires that the death certificate be axed Division of Vital Records, P.O. Box 68760, use jo paga 2 s certificate has Physician: funeral director After this To the Hospital or Attending Pt within 24 hours effer death.
To the Funeral Director: After th completely filled in by the funera

Physician

/Medical

Examiner

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Director

Funeral

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Completed

Funeral

Director

r than "natural", or items 23s or 28s-4 show the Medical Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or farms 23a and Injury or other traumatic event, the Medical Examiner mans once.

Physician

Examiner

Examiner

Physician/Medical

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Completed

Be

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/Medical

altimore, Maryland 21215-0020

with the Maryland

25. Was case referred to medical 1 Yes 2 No

> 5 Pending investigation 6 Could not be

ATTENDING

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

PANDACISTOWN, MS 21(33

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

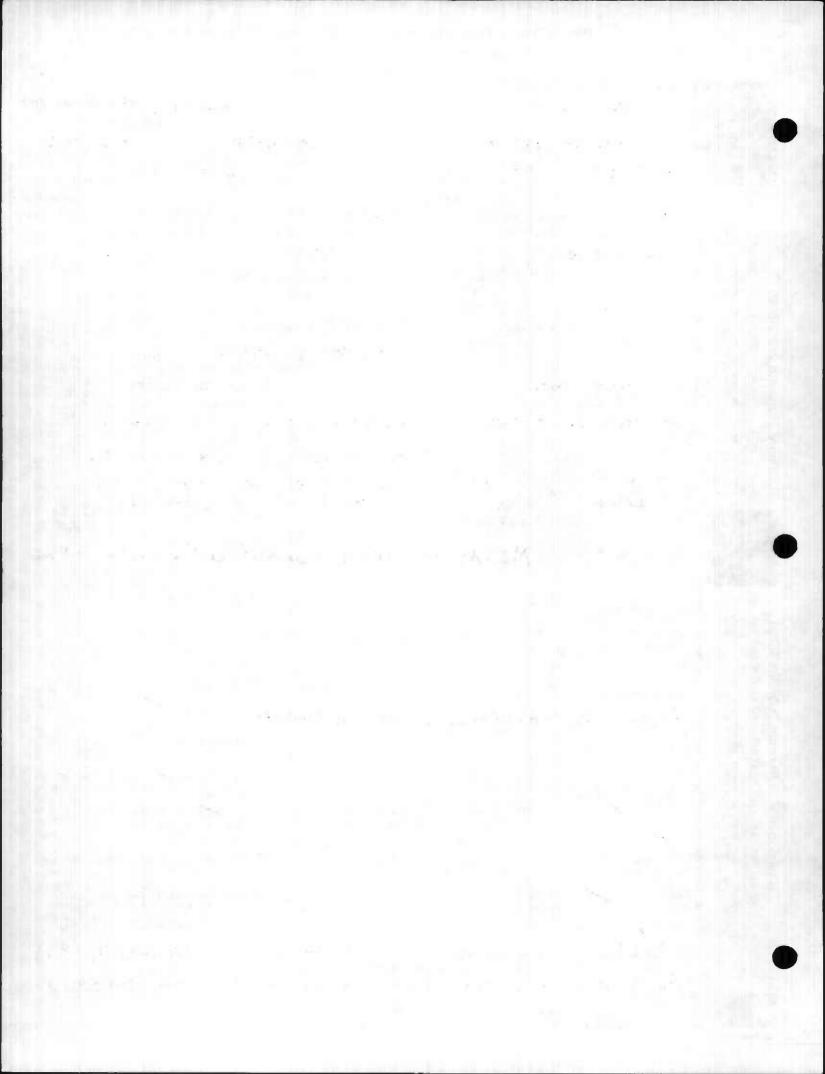
29c. License number 4639 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DESALMO,5310 OLD COURT 31. Date filed (Month, Day, Year)

32. Registrar's Signature Dener

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Month 1999 Eugene J. Roberts January 11, 7:30 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing Home Olney Montgomery | H Undar 1 Year | H Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 9. Birthplaca (St. (Month, Day, Year) | Virginia 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Country) 1⊠M 2□ F 90 Yrs 577-09-3548 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 15311 Pine Orchard Drive, Apt. 3E 20906 USA 12. Was Decedant Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 5+ Patent Attorney Law 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Wert B. Roberts Eugenia B. Coghill 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) 20906 Louise E. Roberts (wife) 15311 Pine Orchard Drive, Apt. 3E, Silver Spring, MD 20b. Placa of Disposition (Nama of cematery, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 1/14/99 Silver Spring, MD 22. Nama and Addrass of Facility Francis J. Collins Funeral 21. Signatura of Funaral Sarvice Licensas Home, Inc. 500 University Blvd. West WER. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Immediata Causa (Final disaasa or condition rasulting in daath) Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Cause (Diseasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Wara autopsy findings 24a. Was an autopsy performed? available prior to completion of ceuse of death? 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medicel axaminar? 26. Placa of Death (Chack only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3□ DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? Natural 5 Panding

ii or Attending Physician: The lew requires that the death certificate be executed effecteders.

effected restrictions that certificate has been signed by the ettending physician and d in by the fundant director, page 2 should be deteched for use as the bundertransit

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical ģ Completed Be 2 Certification: the Funeral Director of the Fu

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6 items 23a

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permit. Pages 1 end 2 should be filed within 7. Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic evant, the Medit once.

Physician /Medical

Examiner

Director

Funeral

by

Completed

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traumatic evant, the Magical Examiner must be notified at

with the Marylend

filed within 72 hours efter death

21215-0020

Baltimore, Maryland

To the Hosp within 24 hor To the Fune completely fi

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

[In the discrete of the causa(s) and manner as stated. In the discrete of the causa(s) and manner stated. In the causa(s) and manner stated. 29a. Cartifiar (Check only one) 29b. Signature and title of certifier. 29c. Licansa numbar 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated ceusa of death (Type, Print) 3305 North Leisure C. Ozanne-Blankfard MD Silve Society Mary 1

28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)

State Registrar

Medical

2 Accidant

4 Homicida

3 Suicida

31. Data filad (Month, Day, Year) **JAN 13** 1999

invastigation

6 Could not ba datarminad

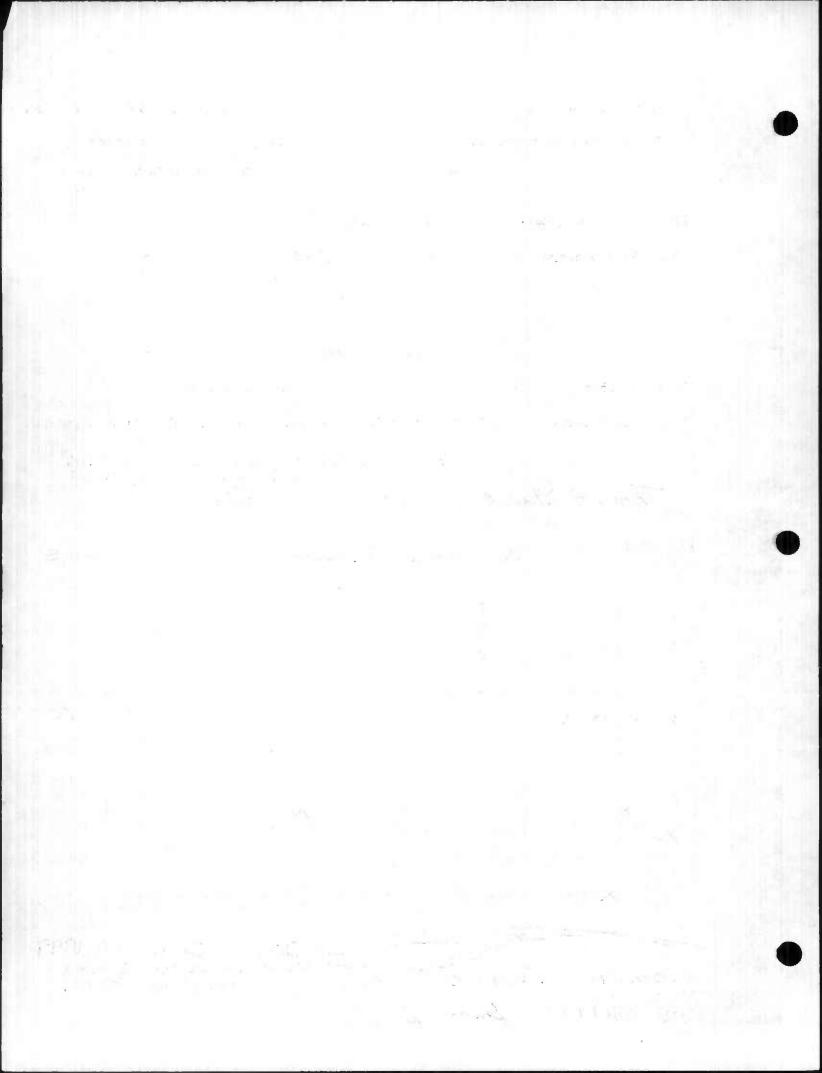
32. Ragistrar's Signatura

1 Yas 2 No

Silve Spring Mary land

Location (Straat and Number or Rural Routa Number, City or Town, Stata)

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day Month MURTEL ROBERTS B. 11:40 PM JANUARY 10 1999 4a. Facility Nama (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death WILSON HEALTH CARE CENTER GAITHERSBURG MONTGOMERY H Under 1 Yaar H Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MARCH 26, 1917 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stete or Foreign 1 M 2 F ILL INO IS 018 16 3891 81 Yrs. Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1⊠ Yes 2 No MD. MONTGOMERY GAITHERSBURG 10e. Streel and Number 10f. Zip Code 10g. Citizen of What Country? 301 RUSSELL AVENUE 20877 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedanf of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, While, etc. 11. Marifal Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade com 16a, Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) est grada complated) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ELMER WILLIAM BEATTY MURIEL SWAN KAYE 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) STEPHEN S. ROBERTS, SON 900 N. STAFFORD ST., ARLINGTON, VIRGINIA 22203 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stste 1 ☐ Burial 2 🗷 Cramation 3 ☐ Removal from State METROPOLITAN CREMATORY 1/12/99 ALEXANDRIA, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licansae 23 MURTEL Address BARBER FUNERAL HOME Hur P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intarvsl Betwaan Onset and Death Immediate Cause (Finel week disease or condition resulting in death) pheumonia arkinsun) vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions confribuling to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was sn autopsy completion of cause of death?

Physiclan /Medical Examiner

attanding physician and for use as the burial-transit tha death certificate be axecuted

signed by the at

been sig

s cartificate has b

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this cartifics completely filled in by the funeral director.

O

P.O. Box 68760,

Division of Vital Records.

permit. Page Department of Important: If any injury or once.

Physician

/Medical

Director

Funeral

by

Completed

Examiner

Funeral

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic svent, tra Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "naturel", or item Inty or other traumatic event, the Medical Examination.

Baltimore, Maryland 21215-0020

with the Maryland

death

Physician/Medical P Completed Be 2 Certification:

edical

examiner?

27. Manner of Death

1 Neturel

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 Homleide

25. Was casa raferred to medical

5 Pending investigation

8 Could not be

28a. Date of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28e. Placa of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other:

Nursing Homa 5 ☐ Residenca 8 ☐ Other (Specify) 28d. Dascribe how injury occurred

1 Yas

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Tertifying Phyeician: To the best of my knowledge, death occurred af tha time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

2 1 No

29b. Signature and title of cartifier

29c. Licensa number

29d. Data signed (Month. Day, Year)

1 ☐ Yes 2 ☐ No

30. Name daddrass of person who completed cause of death (Item 234) (Type, Print)

JOHN R. MELNICK, 911 RUSSELL AVE., GAITHERSBURG, MARYLAND 20877

26. Placa of Death (Check only one)

State Registrar 31. Dafa filed (Month, Day, Year) JAN 1 2 1999 32. Registrar's Signature

souls

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11, 1999 4:20 AM Andris Roess January /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not Institution, give street end number) 4c. County of Death Examiner Silver Spring Medlantic Manor at Layhill Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Yrs **Director** 058-34-8285 56 Feb. 2, 1942 Latvia Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiene. other than "netural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 X Yes 2 No Directo Poolesville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death v 20837 Latvia 17676 Kohlhoss Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status MYes 2 No If Yes, Give 1964— Year or Dates: 1970 filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Canvas Manufacturing event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Peges 1 end 2 should be fill ment of Health end Mentel Hant: If Item 27 is marked oth jury or other trsumatic even Be 2 Aleksandrs Roess Alma Kampe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aija E. Roess / wife 17676 Kohlhoss Road, Poolesville, Maryland 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) January 12, 1999 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State permit. Pege Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematory 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signatu M00831 n faurence 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a Part. Enter the dreame or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physiclan** /Medical Immediate Cause (Finel Terminal Cancer Gastric 24 months disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Cirrhosis of the Liver 24 months The law requires that the deeth certificate be executed physician end s the burief-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Malnourished and Electrolyte Imbalance 24 months Physician/Medical Due to (or as a consequence of): for use es t 23b. Did tobacco use contribute to the cause of death? signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☒ Unknown à 24b. Were eutopsy findings avellable prior to completion of cause of death? been si 24a. Wes an autopsy Completed performed? certificate hes b 1 Yes 2 No 1 Tyes 2 No. or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) After thi 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Yes 2 No thin 24 hours efter deeth.

the Funeral Director: Al deeth. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital edical 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) To

Registrar

Gary W. Jones, M.D. 31. Date filed (Month, Day, Year) **JAN 12** 1999

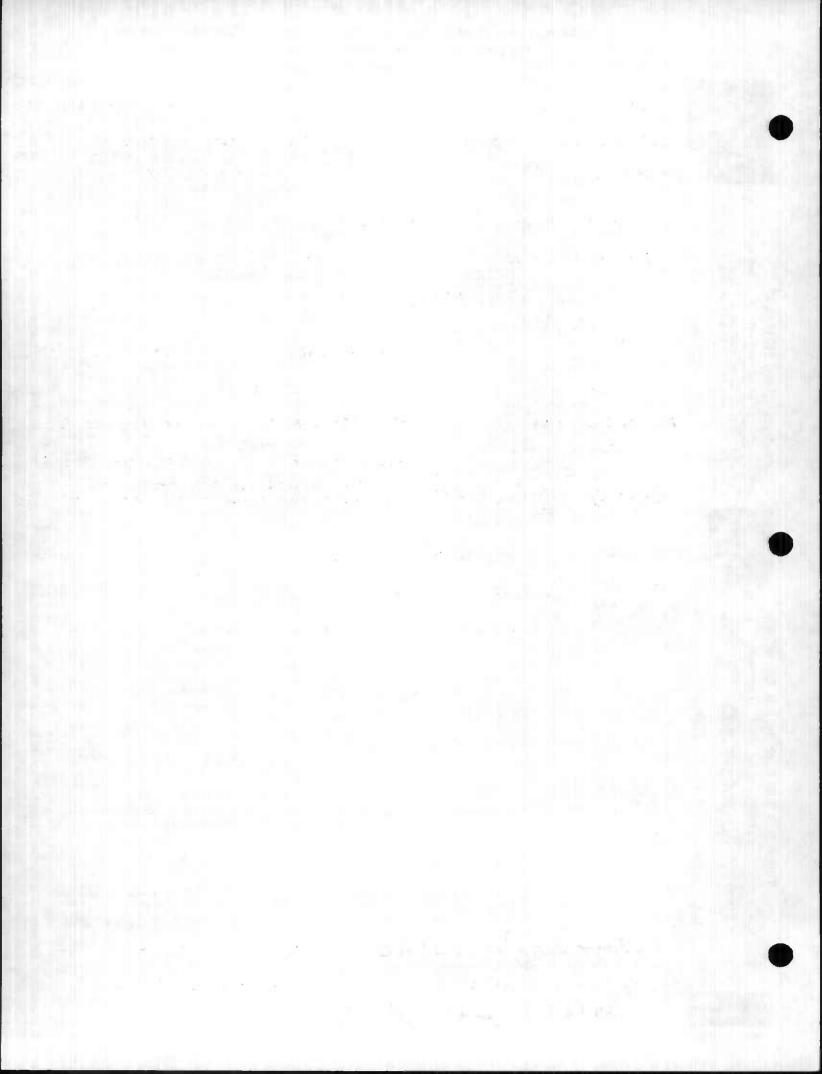
32. Registrar's Signature

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

11305 Pitsea Drive, Beltsville, Maryland 20705-1757

D30111

January 11, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth THEODORE ROGERS 5. 9:00 AM 4c. County of Death 4e. Fecility Name (If not institution, give straet and number) 4b. City, Town, or Location of Deeth HEALTH CARE

Physician /Medical **Examiner Funeral** Director the Maryland Directo death with þ

HYATTSVILLE GEORGES # Under 1 Year | if Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 7, 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (State or Foraign Country) 1 M 2□ F Months 578-18-5320 79 Maryland Usuel Residance of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Wedical Examinar must be notified at 10d. inside City Limits 1 ☐ Yes 2 ▼ No Maryland Prince George's Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6500 Riggs Road 20783 United States 11. Maritel Stetus 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican indien, Black, White, etc. 1 Never Married 2 Married 1 √Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Yaar or Detes: WW II Completed 16e. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I filed within 7 I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filled wit Department of Health and Mental Hygient Important: if Item 27 is merked other that any Injury or other traumatic event, that once. 12 Clerk Patent Office 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Altamont . Moody Rogers Nellie Agnes Koerner 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Joseph R. Accardi 801 Riverside Drive, (nephew) Pine Beach, NJ 08741 20b. Plece of Disposition (Neme of cemetery, cramatory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesapeake Crematory 1-14-99 Beltsville, Maryland 22 Name and Addrass of Facility
Rapp Funeral Services, P. A. 21. Signature of Funerel Servica Licensee leen 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Entar tha diseese, or complications that caused the death. Do not enter the moda of dying, such es cardiec or raspiratory errest, shock, or heer failura. List only one cause on each line. Approximate Intervel Between Onsel and Deeth **Physician** ANTONIOS Candiovascula Disease /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) Examiner eaks Physician/Medical Examiner The law requires that the death certificate be executed ettending physicien and for use es the buriel-fran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): Box 68760, thet initieted events resulting in death) Lest Due to (or as e consequenca of) P.O. I Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Rancinoma Lung Records, by pege 2 should Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eulopsy performed? Dementia, Juscontical 1□ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) this 27. Menner of Deeth Dete of injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Dascribe how Injury occurred Affer 5 Pending invastigetion s after death.

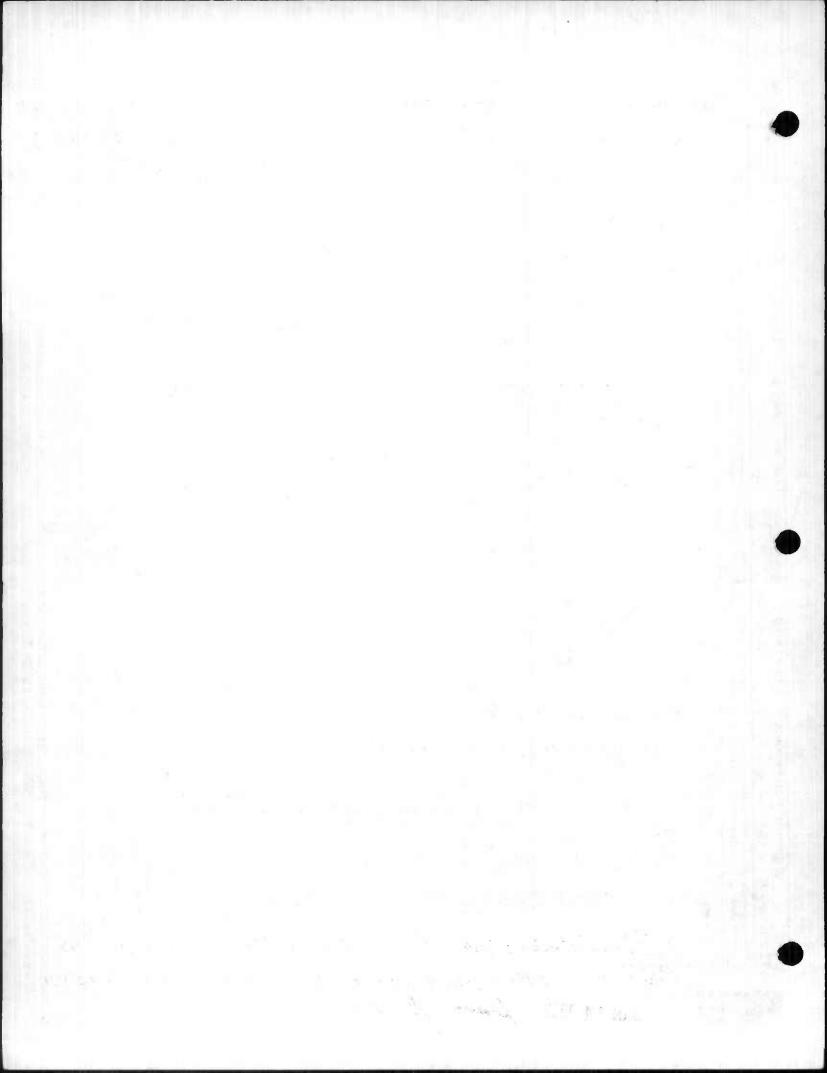
I Director: Aft
of in by the lui 1 ☐ Yes 2 ☐ No 2 Accident NIA 6 Could not be determined 3 Suicide 28e. Plece of Injury - Al home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours at To the Funeral D completely filled I 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steled.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. cai 29e. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Data signed (Month, Dey, Year) ullanley ore hel 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DEVORE MD 4203 Queensburg Not Hyatbuille MD 20181

State

Registrar

31. Date filed (Month, Day, Year)

JAN 14



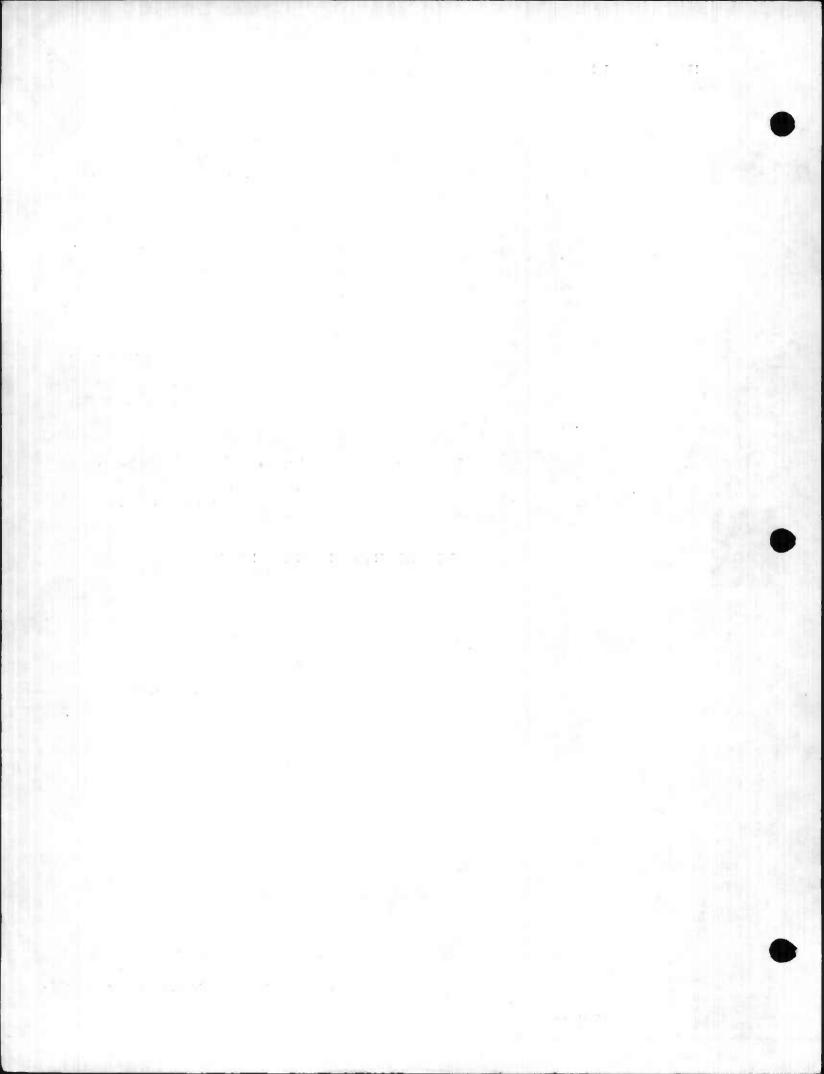
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ROBERT	JAMES

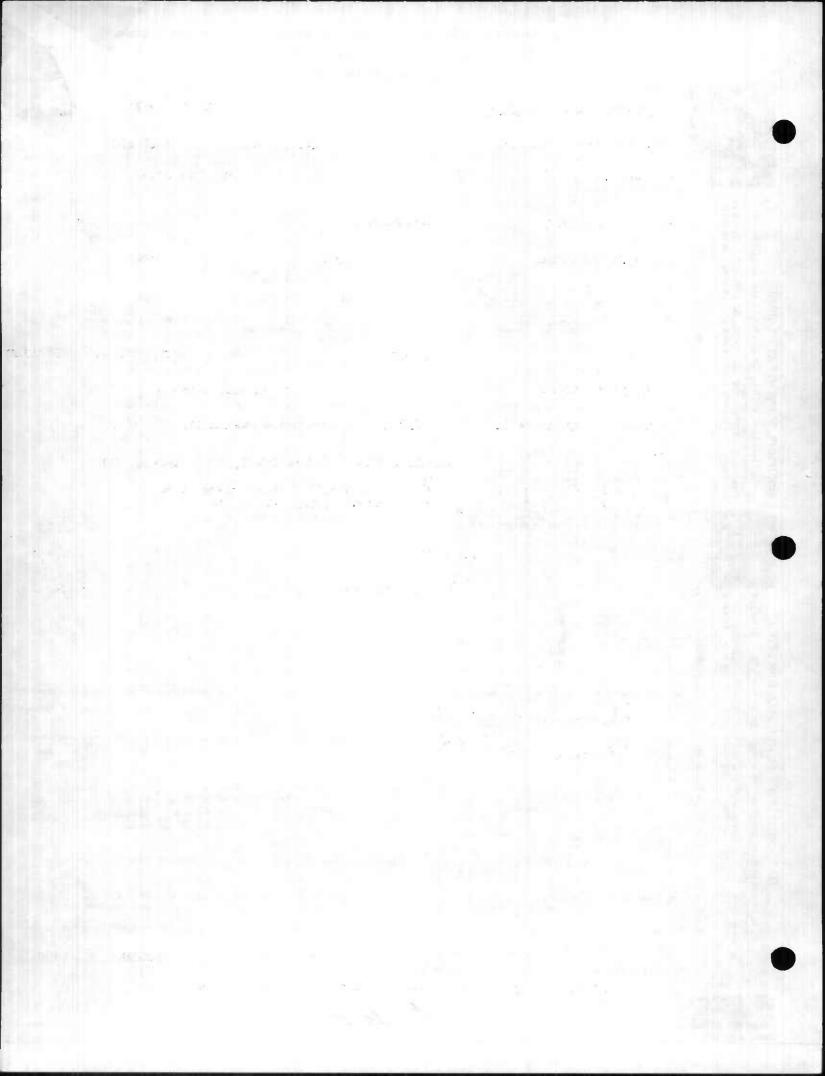
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miner	4a Facility Name (If not ins ALLEGANY COU				ER -CEL	L C		CUMBER	or Location of D LAND		4c. County ALLEG			
ral tor	5. Social Security Number 183-46-9938 Usuat Residence of Decedence	6. Se			last birthday) Yrs.		er 1 Year Days	If Under 24 Hours M	rs. 8. Date of	Birth Day, Ye	ar)	9. Birthple	nce (State or Foreign y) PA	
	10a. Stete 10b. C			10c. Cit	ty, Town or Loc	ation						10	d. Inside City Limits	
Director	MD A	Llegan	у	F	rostbu	g							1 ☐ Yes 2 No	
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by Funeral	11. Meritel Stetus 1 Never Merried 20 3 Widowed 4 Div		12. Was Decedent Armed Forces 1 Yes 2 Hear Yes, Give Yeer or Detes:	? LNo	If	Yes, sp	edent of Hecify Cubi	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.)	No-		e - America k, White, e	ic.	
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	1 ☐ Burial 2 ☑ Crem 4 ☐ Donetion 5 ☐ Ot			9					1/13/99	C	umber	land.	MD	
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Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5	ab.	Due to (d	ROSCLERO or es a consequence es e consequence	Jence of):	VASCULAR	DISEASE			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
2	that initieted events resulting in death) Last	1	d	Due to (o	or es a consequ	ence of	:					1		
Physician/M	Pert II. Other significant co	nditions cor	ntributing to death	but not res	ulting in the un	derlying	cause giv	en in Part I.	23b. (otd tobac	CCO USO CO	ntribute to	the cause of death?	
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edical			sician: To the best ner: On the basis of and menner s	of examine										
Ž	29b. Signature and title of a	ertifier	. 01	00	,	2	9c. Licens	e number		29d.	Date signe	d (Month, D	Pay, Year)	
	16	nu	u bli	will	e no		0.	C.M.E.		JAN	UARY	12, 19	99	
	30. Name and address of p		ompleted cause of	death (Iten	n 23a) (Type, f									
	DENNIS J.CHU				W. 20.11	111	Pen	n Stree	t, Balt	imor	e, Ma	ryland	1 21201	
State	31. Dete filed (Month, Day,	Year) 1990	6	rer's Signe	eture	1								

DHMH 16 Rev 6/95



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niner			, give street and nu				4b. City, Town, or	Location of Deat	4c. County of I	
	SACREI) HEART	HOSPITAL				CUMBERLA		ALLEGA	
al	5. Social Security		6. Sex № M 2 F	7. Aga (In yrs.		If Under 1 Year Months Deys	If Under 24 Hrs Hours Min.	(Month, Da	th y, Year) 9.	Birthplace (Stete or Fo
r	212-24-		Now sell	67	Yrs.			Jul 2	9, 1931	MD
	Usuel Residence	10b. County		10c. City	y, Town or Loc	ation				10d. Inside City L
0	MD	Allega	anv		Cumber	land				↑▼ Yes 2
Director	10e. Street and No	-	Ally		Outlook	10f. Zip Code			10g. Citizen of Whe	et Country?
Ö	717 Sv1	Lvan Ave	nue			2150	2		USA	
Funeral	11. Merital Status		12. Wes Dec	cedent Ever in U.	,S. 13. V	Ves Decedent of I	lispanic Origin? (S	pecify Yas or No	- 14. Race -	American Indian,
by Fur		rried 2 Merri	Armed Filed 1 Yas If Yes, G Year or I	20 No ive		Yes, specify Cub	Specify:	o Micen, etc.)	Specify:	white, etc.
ted	(00	15. Decedent			16e. Deced	ent's Usuel Occup	pation	rkina	16b. Kind of Busin	
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To	George	e W. Run	mer					ouise (J		
14	19e. Informent's N								er, City or Town, Ste	
2			erwife				zenue; Cu	7		502
	20e. Method of Dis		3 Ramoval from	State	cemetery, crem	sition (Neme of letory or other ple		Dete	20c. Location - Cit	y or Town, Stete
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	21. Signeture of F	-uneral Sarvice I	Licensaa	0.4	1 22	Nama and Addre Scarpel	ess of Fecility Li Funera	al Home,	P.A.	
	740	Chulo	220	cupe	N.	Cumberl	and, MD	21502		
	23a. Part1. Enter shock, or he	the disease, or sert failure. List	complications that only one cause on	ceusad the deat each line.	Do not ente	er the mode of dyi	ng, such as cerdia	c or respiratory a	rrast,	Approximeta Intervel Betwee Onset and Dee
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by Physician/Me	resulting in death)	nificant conditto	d	deeth but not res	ulting in the un		ven in Pert I.	1 🗆 24a. Was perfe	Yes 2☐♠o 3 san autopsy ormed?	Probably 4 Uni 24b. Were autopsy find aveilable prior to completion of caus of death?
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Jan 10, 1999 JOHN VERNON RAFTER 5:30 am /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CUMBERLAND
If Undar 24 Hrs. 8. 318 SUNSET DRIVE ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1 M 2□ F Days Hours Min Yrs Director 219-14-6067 73 Nov 18, 1925 OH Usual Residence of Deceden with the Maryland 10a. State 10b. County show 10c, City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at Director 1 ¥ Yas 2 □ No Allegany MD Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 Sunset Drive death v 21502 Funeral IISA 12. Was Decedant Evar In U,S. Armed Forces? 1 M Yes 2 □ No if Yes, Give Year or Dates: WW II 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: py Specify 3 ₩ Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 12 Retired Auditor Dept. of H.E.W. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi and Mental H Is marked out Be John Van Rafter Doris (Gough) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If from 27 is n Carolyn L. Koudry-daughter 12512 Two Farm Drive; Silver Spring, MD 20904 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Park 01/14 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Causa (Final disease or condition rasulting in death) uk yrs Arteriosclerotic Heart Disease **Examiner** Due to (or as a consequence of): Examiner certificate be executed -tran Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceusa (Disaase or Injury that Initiated evants rasulting In death) Last pue Due to (or as e consequence of): attending physician for use as the buriel-Box 68760, Physician/Medical Dua to (or as a consequence of) The law requires that the death P.O. P Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco usa contributa to the cause of death? signed by 1 Yes 2 No 3 Probably Junknown S/P Bypass surgery Records, Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy Hypothermia page 2 No certificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was cese referred to medicel examinar?

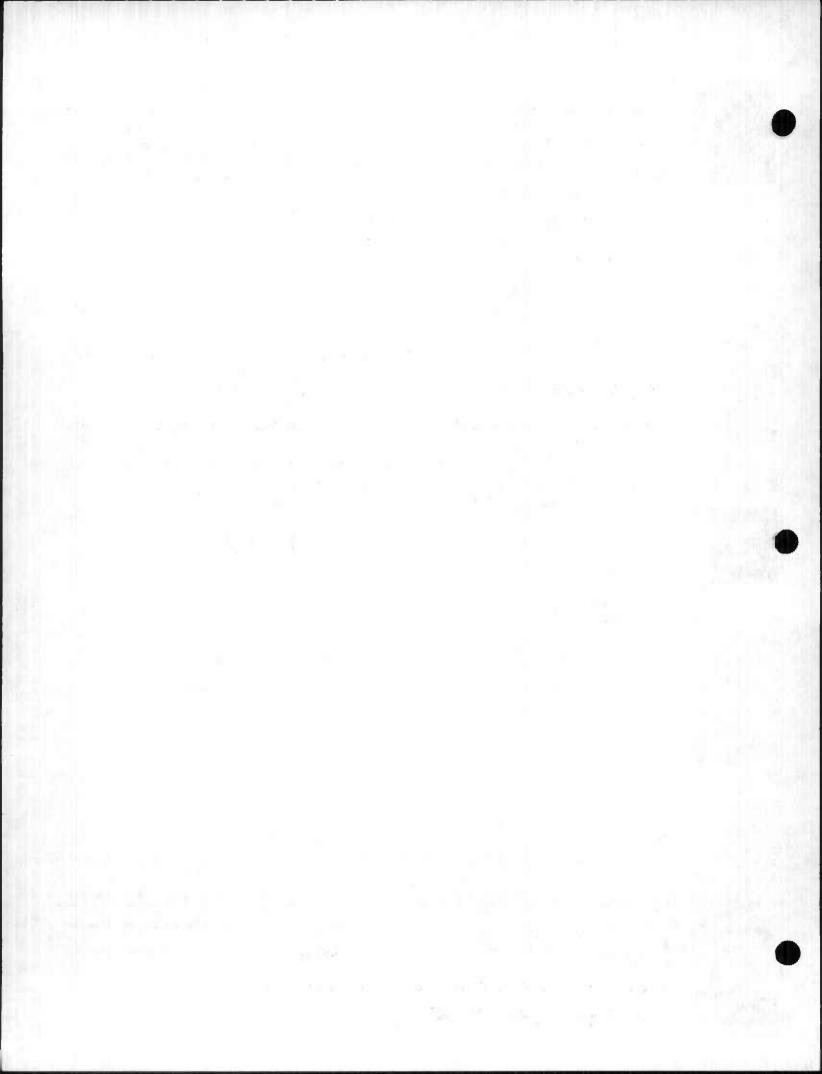
Yas 2□ No Be 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Certification: To General Control (Specify) this 28a. Data of Injury (Month, Day Year) funeral 27. Manger of Death 28b. Time of Injury how injury occurred 28c. Injury at Work? After 1 Natural 2 Accidant 5 Panding investigation after death. 1 Yas 2 No 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicida • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. To the Hosp within 24 hou To the Fune completely fil Medical 29a. Cartifier 29b. Signaty and title of partis 29c. Licansa number 29d. Data signed (Month, Day, Year) Jan. 10, 1999 D09157 6 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 226 Paul Snow; 124 W. Third Street; Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State

DHMH 16 Rev 6/95

Registrar

JAN 1 1 1999



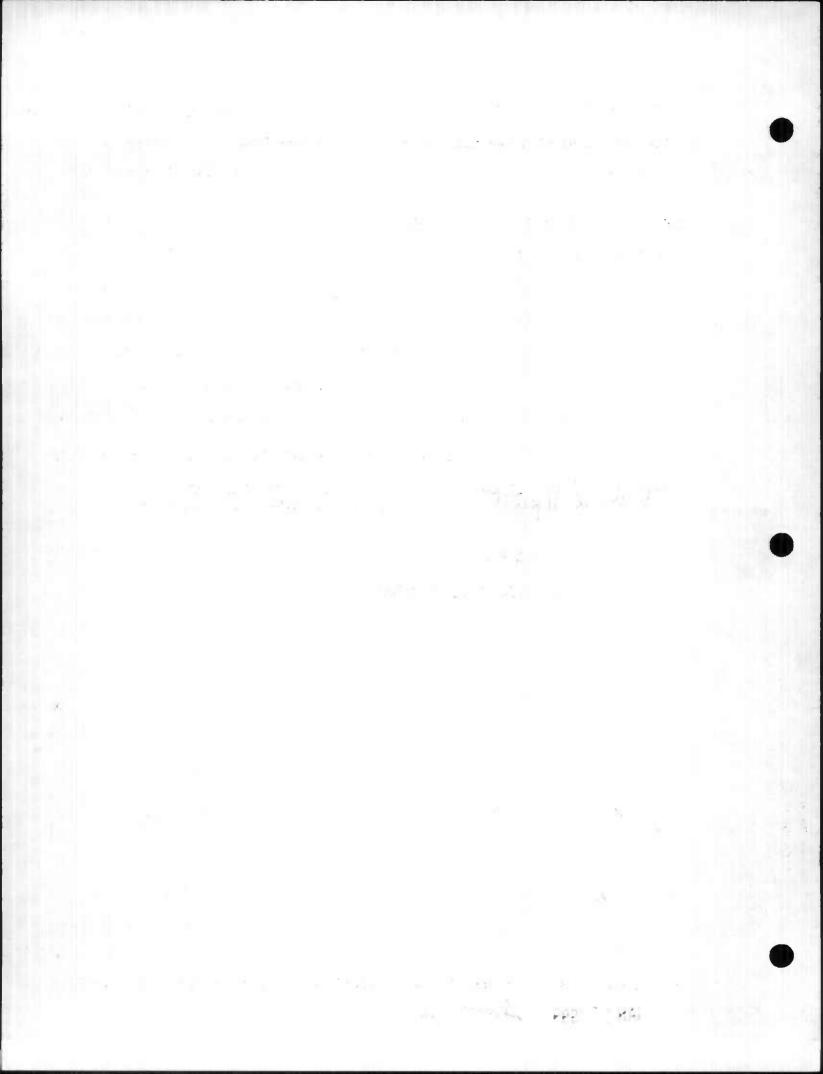
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MARY HENRIETTA 1999 January 8, 7:50 p.m. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Memorial Hospital & Medical Center Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 13 1915 Birthplace (State or Foreign Country)
 MARY LAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours 1 M 2 XF Months Yrs. Director 216-66-0874 83 Usual Rasidenca of Decedent filed within 72 hours efter death with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits •how r 28a-f show 1 ☐ Yes 2X No Directo MARYLAND ALLEGANY CUMBERLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23s or the Medical Examiner must be 12809 MASON ROAD N.E. 21502 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Giva Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: WHITE à 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) HOUSE WIFE 8 HOUSE WIFE .. Peges 1 and 2 should be filed w tment of Health end Mental Hygie tant: If Item 27 is marked other ti jury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES T. TRAIL AMANDA ELIZABETH SWAIN 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Health er Important: If Item 27 is eny injury or other trau 11007 M.V.SMITH ROAD N.E. FLINTSTONE MARYLAND 21530 DAUGHTER ELIZABETH HAINES 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other plece) 1 N Buriel 2 ☐ Cremation 3 ☐ Removal from State SUNSET CEMETERY JANUARY 11,1999 CUMBERLAND MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME fernis di 404 DECATUR STREET CUMBERLAND MARYLAND enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Intarval Batween Onset end Deeth 23a. Part1. Enter the disease, or complications that ceused the death. Do not ente shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final 2 MONTH a. SEPSIS disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner 2 MONTH b. PERFORATED VISCOUS that the death certificate be executed physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 use signed by the a d be deteched f 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of ceuse of death? certificate has birector, pege 2 s 1 ∏ Yas 2 NO No 1 ☐ Yes 2DX No Division of Vital or Attending Physician: funeral director, 25. Was casa raferrad to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spacify) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 No 10 After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural Injury 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) To the To the To the I 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 5 1999 D 23371 January 30. Nama and address of parson who complated causa of daath (Itam 23a) (Type, Print) $n\omega$ Johnson Heights Medical Building, Cumberland, MD Zaman, Qamar, M.D., 31. Date filed (Month, Day, Yaar) 22. Ragistrar's Signature State JAN 1 1 1999 Registrar

DHMH 16 Rev 6/95

216-66-0874



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State of Maryland / Department of Health and Mental Hygiene

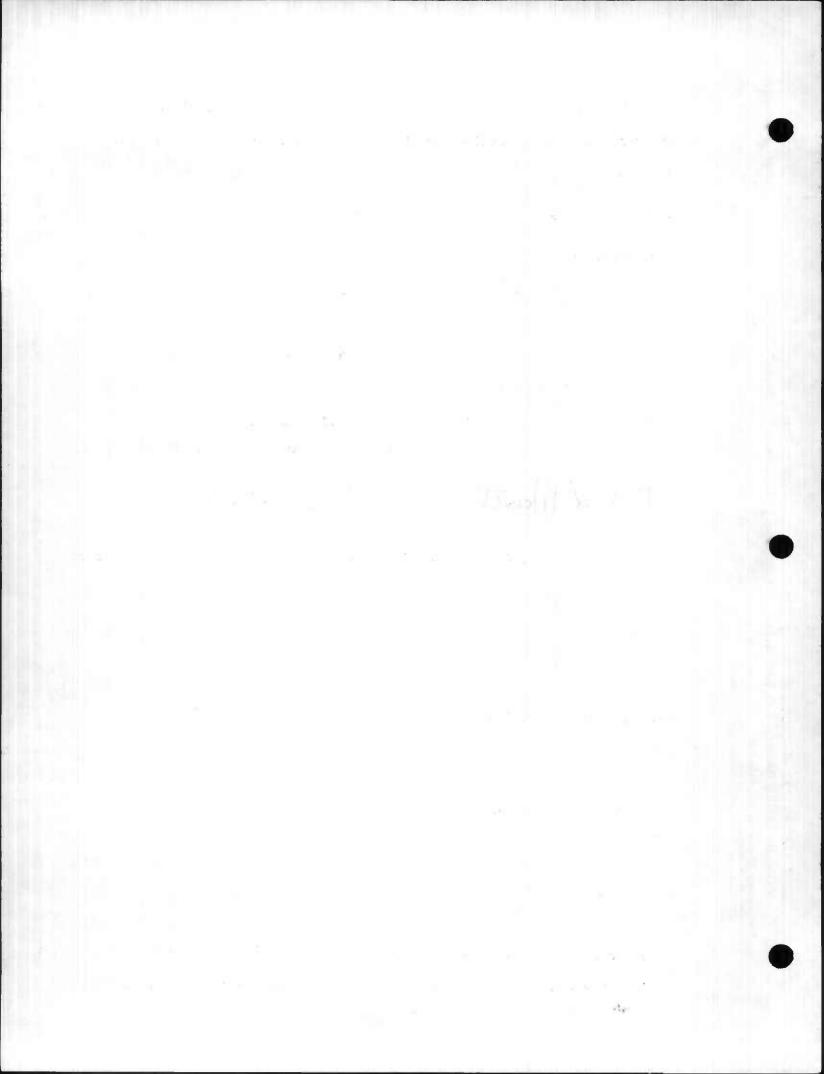
Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JANUARY 10 1999 ROBERT KEITH REDMAN 6:20 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 10XM 20 F Yrs. 65 234-40-3402 Director MARCH 24 1933 W.VA. Usuel Residence of Decedent with the Maryland 10e State 10h Count 10c. City. Town or Location 10d. Inside Clty Limits 28a-f ahow r than "natural", or items 23s or 28s-f short the Med sail Examiner must be notified at W. VA. MINERAL CARPENDALE 1 Yes No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RFD#1 BOX#294 U.S.A. 26753 Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after TY□Yes 2□No If Yes, Give Year or Dates: US ARMY 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify Specify: WHITE þ 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tite. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 10 Bethlehem Steel CO. Pipefitter other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event JOHN ERNEST REDMAN VIOLA MELINDA GEORGE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, Informent's Name/Relationship (Type, Print) DARREN REDMAN SON RIDGELEY, W.VA. 26753 20a. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State ROCKTOGAP VET CEMETERY JAN 12 1999 FLINTSTONE MD. 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility any ir MERRITT-ADAMS FUNERAL HOME 1 404 DECATUR STREET CUMBERLAND MARYLAND pilotations that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, one cause on each line. ale ox 23a. Perf1. Enter the diseese, or com shock, or heart failure. List only Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final BRONCHOGENIC CARCINOMA 3 WEEKS disease or condition resulting in death) Examiner Due to (or es a consequence of) Physiclan/Medical Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): resulting in deeth) Lest ed by the a 23b. Did tobacco use contribute to the cause of deeth? Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by CHRONIC OBSTRUCTIVE LUNG DISEASE þ 2 24b. Were eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy peeu The law has page 2 2 No 1 Yes 2 No 1 Yes oral Director: After this certificate filled in by the funeral director, pag or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitat: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) after 4 Homicide within 24 hours a
To the Funeral C
completely filled Certifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es steled.

2 Medicat Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 8 D-14865 bustian2 Thera 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ROBUSTIANO BARRERA M.D., MEMORIAL MEDICAL BLDG., CUMBERLAND, MD 21502 1999 32. Registrar's Signeture State Aportal Registrar

DHMH 16 Rev 6/95

234-40-3402

ROBERT REDMAN

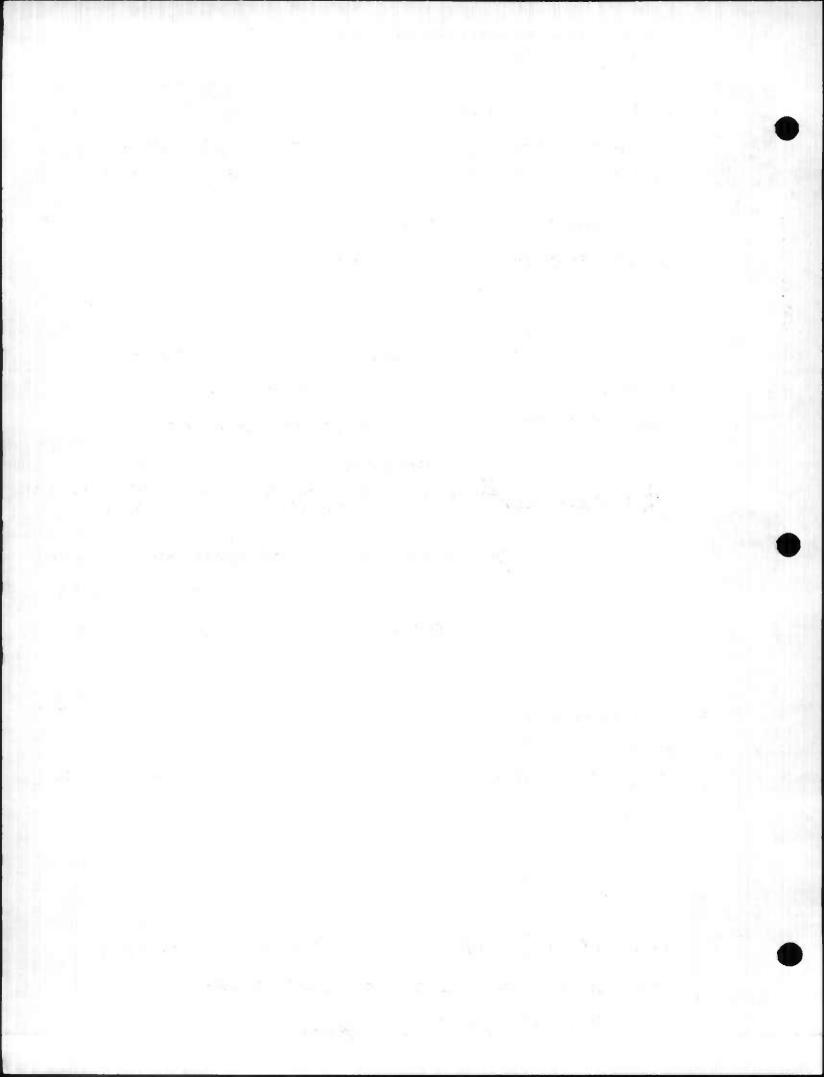


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State of Maryland / Department of Health and Mental Hygiene 9 9 1 6 5 0

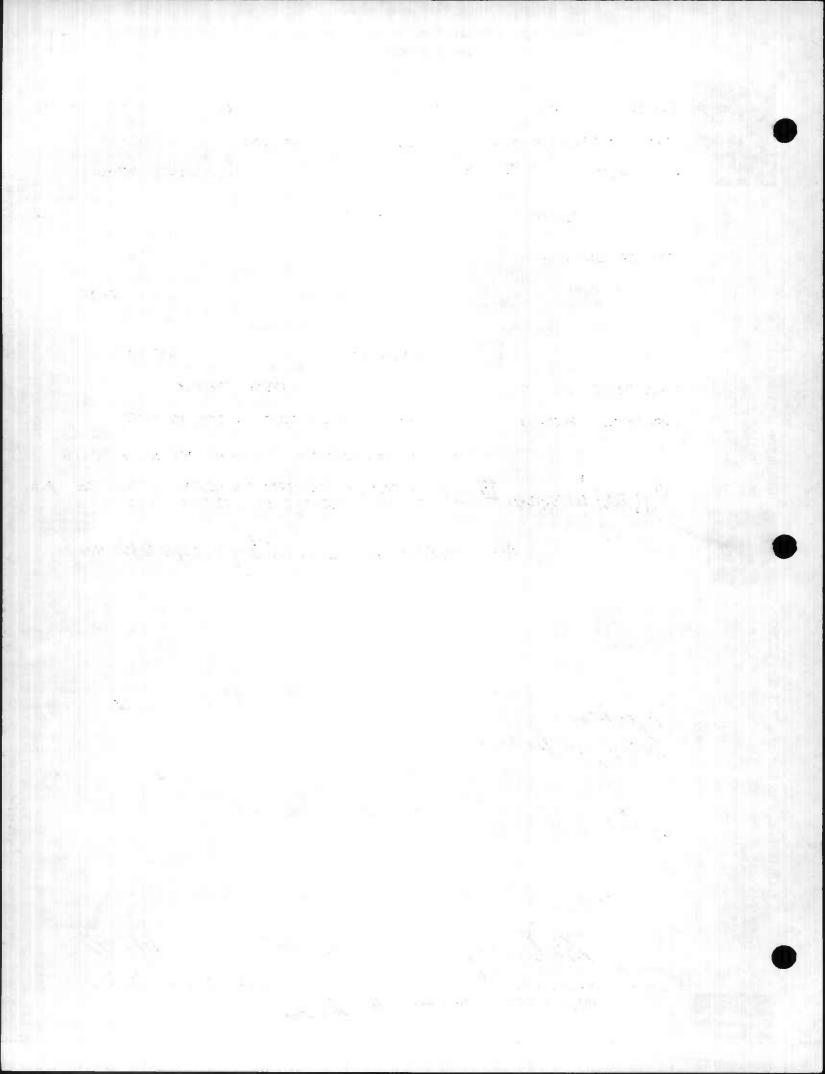
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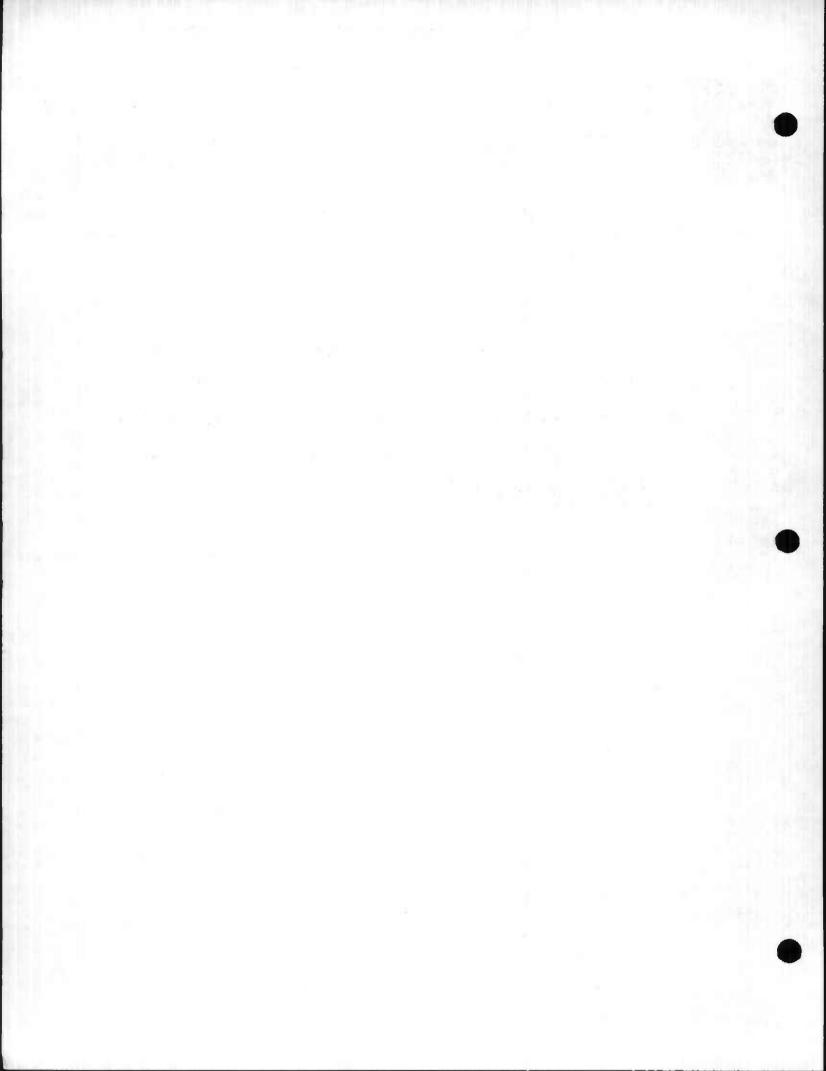
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led within 72 ho ygiene. Ner than "naturi rt, me Medical Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	/Gi	cedent's Us ive kind of w b. DO NOT	vork done	during most	of worki	ng	16b. Kind of B	Business/Inc	dustry
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be file to the event.	17. Father's Name (First, Middle, Li	ast)					18. Mothe	's Name	(First, Middle, I	Maiden Sumai	me)	
should be nd Mentel marked o umatic eve	RALPH HENRY LEW	IS, SR.					MA	RION	SHRYO	CK		
	19a. Informant's Name/Relationshi	lp (Type, Print)		19b. Ma	ailing Addre	ss (Stree	t end Numbe	r or Rure	I Route Number	r, City or Town	, Stete, Zip	Code)
CANE	JOHN SKOCZ / HUS	SBAND		8202	2 ING	LETO	V CIRC	LE,	EASTON,	MD 216	501	
permit. Pages 1 end Depertment of Heelt Important: If item 21 any injury or other page.	20a. Method of Disposition 1X Burlal 2 Cremetion 3 4 Donation 5 Other (Spe		State	Plece of Dis cemetery, ci	rematory or	r other pla		1-		20c. Location BEULAH		
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The Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death. The Eurora is Director: After this certificate has been signed by the entanding physician and pletely filled in by the funeral director, page 2 should be detached for use as the buriel-transit director, page 2 should be detached for use as the buriel-transit deficient of the funeral director. To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant condition Hyperims for the condition of the co	a. No. b c d Hospital: 1 1 28e. Date (Montation and be bened 28e. Place building the present and the presen	Due to (Due to	cor as a consider as a conside	ell Cu sequence of Marketing	DOA Of 28c. Injuiced at the ton, In my	ing, such as of the second of	of Death	23b. Did to 1 Y 24e. Wes e performe 5 Reside 28d. Describe house and due to the ced et the time, described and the ced et	obacco use codes 2 No ne eutopsy med? No ne eutopsy med? No ne) ence 8 Otto ow injury occur in	pontribute to 3 Proi	othe cause of deal bebly 4 Unknown under europsy finding allable prior to mpletion of cause deeth? Yes 2 No If Route Number, tated. the cause(s) Day, Year)
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Physic	ian								Month	Day	Year	3. Time of Death
/Med		Frieda Mari					- (40	City Town on	Januar	, , ,	999	4:30PM
Exam	ner	4a. Facility Name (If not institution, g		er)			4		Location of Deat			
		9920 Green Valle	_	A # #		If Under 1	Vees	Union .			Frede	
Funera Directo		138-30-8359	Sex 1 □ M 2 🖾 F	Aga (In yrs. las 101	Yrs.		Days	If Under 24 Hrs Hours Min	NOV. 2	th 27, Year) 11, 1897	9. Birthpl Coun ES	laca (Stata or Foreign try) tonia
pu *		Usuel Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation					14	0d. inside City Limits
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s 23	a	9920 Green Vall	1					21791			U.S.A	
within 72 hours efter deeth with the Maryland lene. than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at	y Funeral Director	11. Marital Status 1 Naver Married 2 Married	12. Was Deceda Armed Force 1 Yes 21 If Yes, Give	es?		Nas Deceda f Yes, specif 1 □ Yes 2			Specify Yas or No to Rican, atc.)	Specif	ck, White,	atc.
permit. Pages 1 and 2 should be filled within 72 hours eft Department of Health and Mental hygiene. Important: If Hem 27 is marked other than "natural", or nny Injury or other traumatic event, the Medical Example.	d by	3 ☑ Widowed 4 ☐ Divorced	Yaar or Data	is:				-,,-		Specin	Whi	te
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E = N -		Roy E. Heaney/ so	n-in-law			Libert			rederick	, MD 21	701	
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Physician: The in this certificate he ral director, page	Be	25. Was case referred to medical examiner?	Alexandra I				1 00		ath (Check only	one)		
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ding h. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		njury Day Year)	Bb. Tima of Injury	M 28	c. Injury Work	at ? ′es 2 □ No	28d. Describe	how injury occur	red	
2 0 0	fici	3 Suicide 6 Could not I	286. Piece of	Injury - At hom	e, farm, stre	eet, factory,	office			Street and Num I	ber or Rura	l Route Number,
or A effer Direct	ert	4 ☐ Homicide	building,	etc. (Specify)					City or To	wn, State)		
To the Hospital or Attenwithin 24 hours effer deat To the Funeral Director: completely filled in by the	edical C	29e. Certifier (Check only one) 1 Certifying P	nysician: To the be miner: On the basis	s of examination	edge, deeth	occurred et	the tim	e, date and place Inion, death occ	e, and due to the urred at the time,	cause(s) and me date and place,	enner as st and due to	ated. the causa(s)
the the	M	29b. Signatura and title of certifier	and mannar	Stateu.		29e	Lingnes	number		29d. Date signe	et (Month)	Day Vasel
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		30. Neme and address of person who	completed cause of	of deeth (Item 2	3a) (Type,	Print)						
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Regist	rar	JAN 1 11	999	renewa	19	· Sp	mark	2				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Richard Coale Sappington Sr. 1999 Jan. 4 8:45pm 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Glade Valley Nursing & Rehabilitation Ctr. Walkersville Frederick If Under 24 Hrs. 8. Defe of Birth Hours Min. (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year Birthplece (State or Foreign Country) 82 Months Deys 219-07-5279 6, Maryland Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Frederick Libertytown 1X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. Box 263 21762 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marifal Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 Never Married 2 Married I X Yes 2 □ No If Yes, Give 1 ☐ Yes 2 No Specify: Yeer or Detes: 3 2 Widowed 4 Divorced 1945 White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treasurer, vice-15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) president/ business manager car dealership 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Madge G. Sappington W. Gilmore Sappington 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Madge S. Lamb/ daughter P.O. Box 263 Libertytown, MD 21762 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State St. Peter's Cemetery 1/8/99 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Hartzler Funeral Home of Fungral Service Licens 11802 Liberty Rd. Libertytown, MD 21762 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es a consequence of): Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

Physician /Medicai Examiner

The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

Physician

/Medical

Examiner

Funeral

Director

ral, or items 23s or 28s-f show Examiner must be notified at

"natural", or

27 is marked or traumatic even

permit. Pages 1 and 2: Department of Health ar Important: if Itam 27 is any injury or other trau

Director

Funeral

þ

Be Completed

2

Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

the SE signed by the ai

Physician/Medical Examiner by Completed Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certification by the funeral director, I Be 2 Medical Certification: within 24 hours a To the Funeral C completely filled

			24a. Wes en europsy performed? 24b. Were eut eveileble recompletion of deeth? 1 \(\text{ Yes} \) 27 No \(1 \text{ Yes} \)	orlor to
25. Wes cese referred to medical		26. Place of De	eeth (Check only one)	
exeminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpet	ient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Deeth 1 Natural 5 Pending 2 Accident Investigation		of 28c. Injury ef	28d. Describe how injury occurred	
3 Suicide 6 Could not be determined		street, fectory, office	28f. Location (Street end Number or Rurel Route City or Town, State)	Number,
29a. Certifier (Check only 2 Medical Exert	ysiclen: To the best of my knowledge, de	eth occurred at the time, date and place	te, end due to the ceuse(s) end menner es steted.	uea(e)

29b. Signeture end little of certifier

31. Date filed (Month, Dey, Yeer)

end menner stated. 29d. Date signed (Mogth, Day, Year)

29c. License number

se of deeth (Item 23e), (Type, Print) rederic

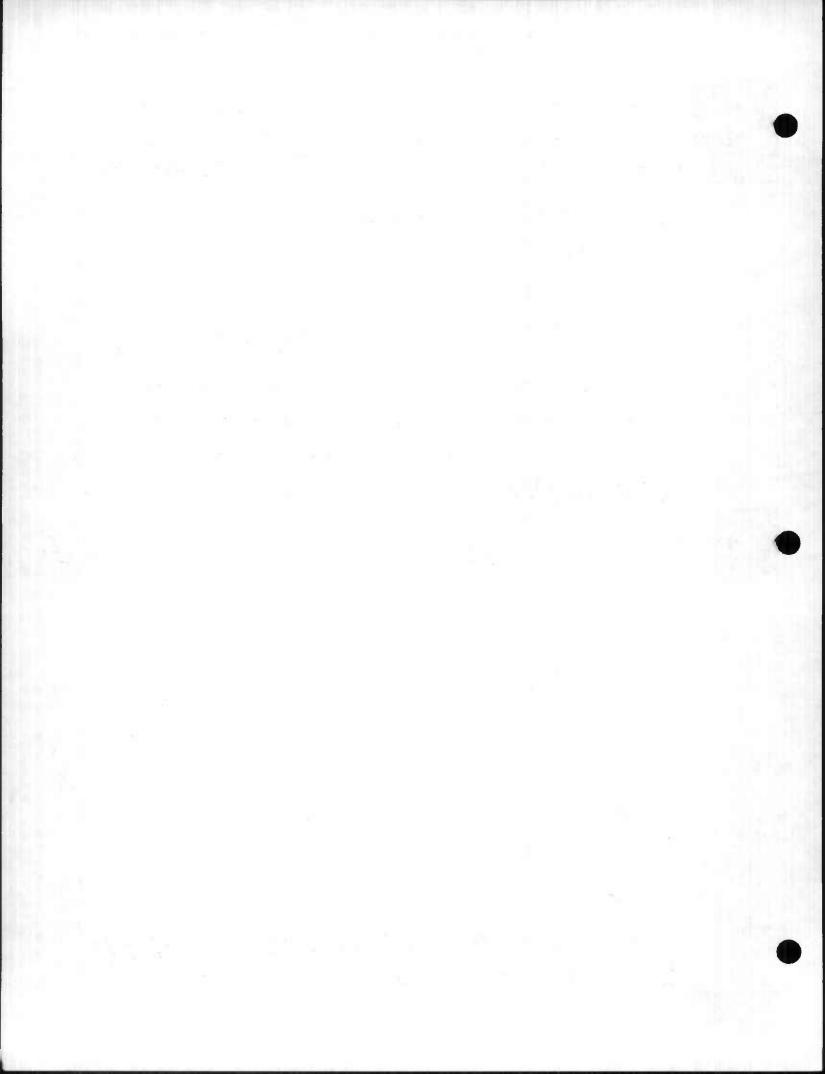
Kaufmann Robert L.

State Registrar

JAN 1 1 1999

32. Registrer's Signeture

To the



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. Amended Item 29d, per Phy. State of Maryland / Department of Health and Mental Hygiene Q 1/11/99, Carroll County, wil Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** Russell Leonard Smith Sr. 1999 4:00pm January /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 10109 Davis Avenue Granite Baltimore 5. Social Security Number 219–12–7183 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) Feb 12 1925 7. Age (In yrs. last birthday) 73 Yrs. Birthplace (State or Foreign Md. **Funeral** Days 10XM 20 F Months Director Usuel Residence of Decedent with the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examinat mast be notified at Md Baltimore Granite 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 10109 Davis Avenue 21163 USA Funeral deeth 12. Was Decedent Ever In U.S. Armed Forces? V☐ Yes 2 ☐ No 17 Yes, Give Year or Detes: 1946 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Bleck, White, etc. nit. Pages 1 and 2 should be filed within 72 hours efter arment of Heelth and Mental thygiene. ortant: if tem 27 is marked other than "natural", or that in luly or other traumatic event, the Medical Example. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) service manager automotive 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Richard Crawley Smith Mary Kay Black 19e. Informent's Name/Relationship (Type, Print)
Mrs. Lennie Smith (spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10109 Davis Ave., Granite, Md. 21163 20b. Place of Disposition (Name of Dete 20c. Location - City or Town, Stete 20a. Method of Disposition St. Alphonsus Cemetery 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-11-99 Woodstock, Md. permit. Page Department of Important: If any Injury of pnce. 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee Haight Funeral Home & Chapel Daige Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel 8 mos. metastatic disease or condition resulting in death) colon canor Examiner Due to (or es e consequence of): Examiner buriel-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): and certificate be exec physician Box 68760 Physician/Medical the Due to (or as a consequence of): 80 esn ö signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? hes page 2 1 Tyes 2 DA 1 Tyes 2 PNO certificate Hospital or Attending Physician:
24 hours efter death.
 Funeral Director: After this certifica director. 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpetient 3 DOA funerai 28e. Dete of Injury (Month, Dey Year) 27. Menney of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) January 8, 1999 29b. Signeture and title of certifier 29c. License number D40850 - ou 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) MD 21225 900 LATON AVE BALTIMME UTTAVIANO MD

DHMH 16 Rev 6/95

State

Registrar

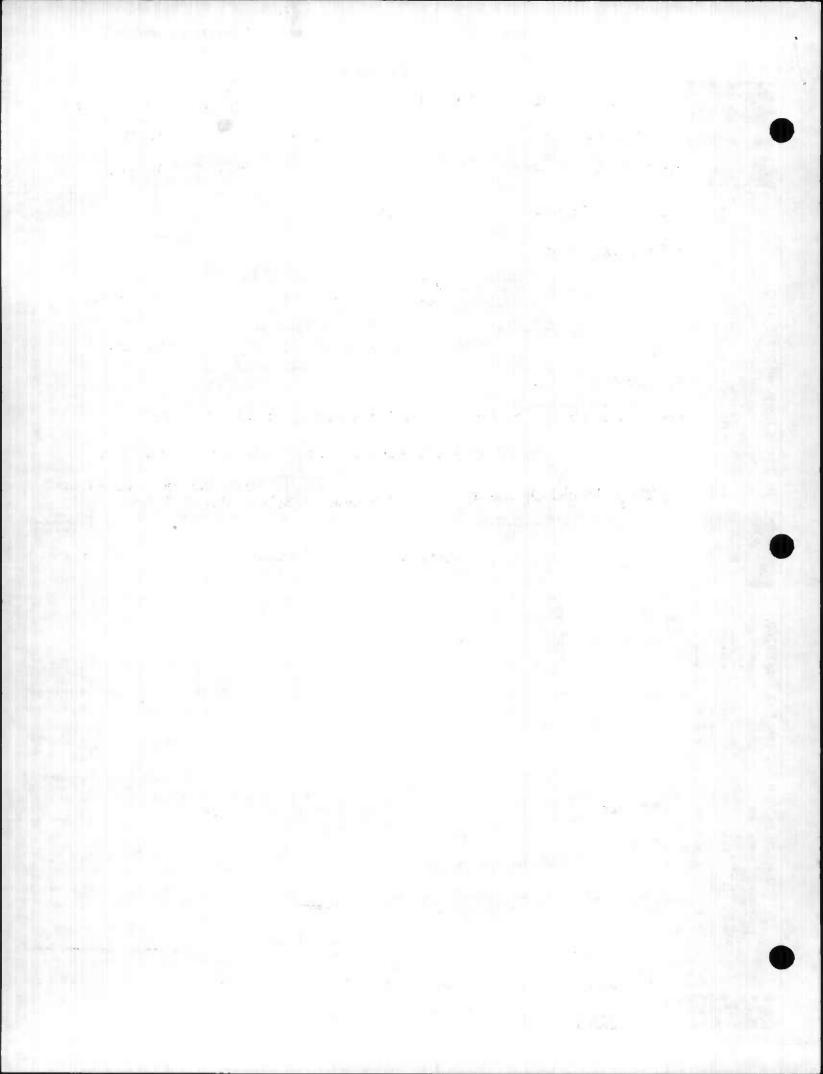
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JAN 1 1 1999

32. Registrer's Signeture

Leneva

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OFISSAM Elma Mackey Schram KO Month **Physician** Yan 05 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sun rise Cane and Rehabilitation for Elklor Elkton H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) Fairhope, PA If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2以F 186-12-6286 92 Yrs Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exampler must be notified at 1 ☐ Yes 2 No Director Cecil Maryland Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 77 Snug Harbor Way 21919 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status e filed within 72 hours after al Hygiene. other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 200 Married 1 Yes 2KMo Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If item 27 is marked other th any injury or other traumatic event, the page. Domestic/Own Home Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Mackey Fannie Palomaki 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine D. Powers/Daughter 661 Shippertown Road, E. Greenwich, RI 02818 20b. Place of Disposition (Neme of cometery, cremetory or other place) January 9, 1999 20a. Method of Disposition NBuriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Broomall, PA Glenwood Memorial Gardens/ 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. PO Box 270, Millington, Maryland 21651-0270 Approximate on each line. 21. Signature of Fur erel Service Licensee 23a. Pert1. En of the disease, or complice shock, or neert feilure. List only one Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ischemic cerebrovascular accident Examiner Due to (or as a consequence of) Examiner hypertension 1eans physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medicai Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown congestive heart failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed paroxysmal atrial fibrillation 1 Yes 2000 1 Yes 2010 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 1□ Yes 2N No Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28c Injury at Work? 28a. Date of Injury (Month, Day Ye 1. Natural 5 Pending investigation 1 Yes 2 N 2 C Accident 6 C Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, afreet, factory, office stuiding, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. 29a. Certifier

P.O. Records, of Vital To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: Atter it completely filled in by the funera Division

Baltimore, Maryland 21215-0020

Box 68760.

Uncham 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Wallace Obenshain, MD, Route 213, Cecilton, Maryland 21913

State Registrar

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31. Dete filed (Month, Dey, Year) JAN 0 8 1999

(Check only one)

29b. Signeture end title of certifier

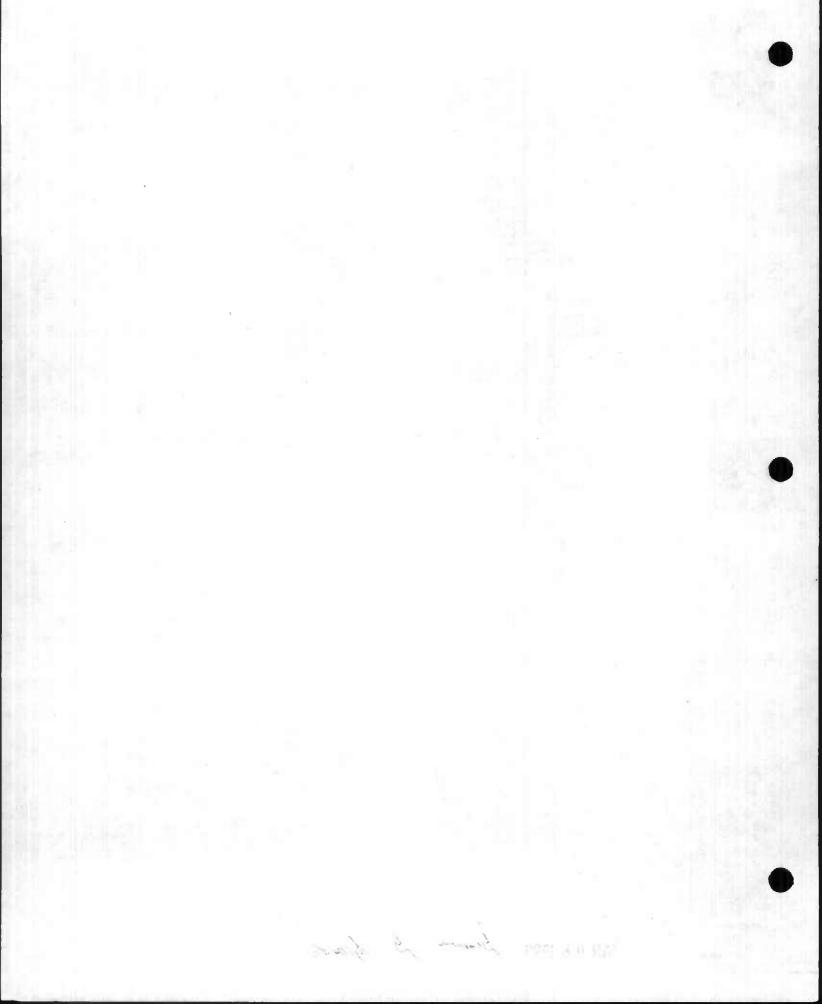
32. Registrar's Signeture

29c. License number

035779

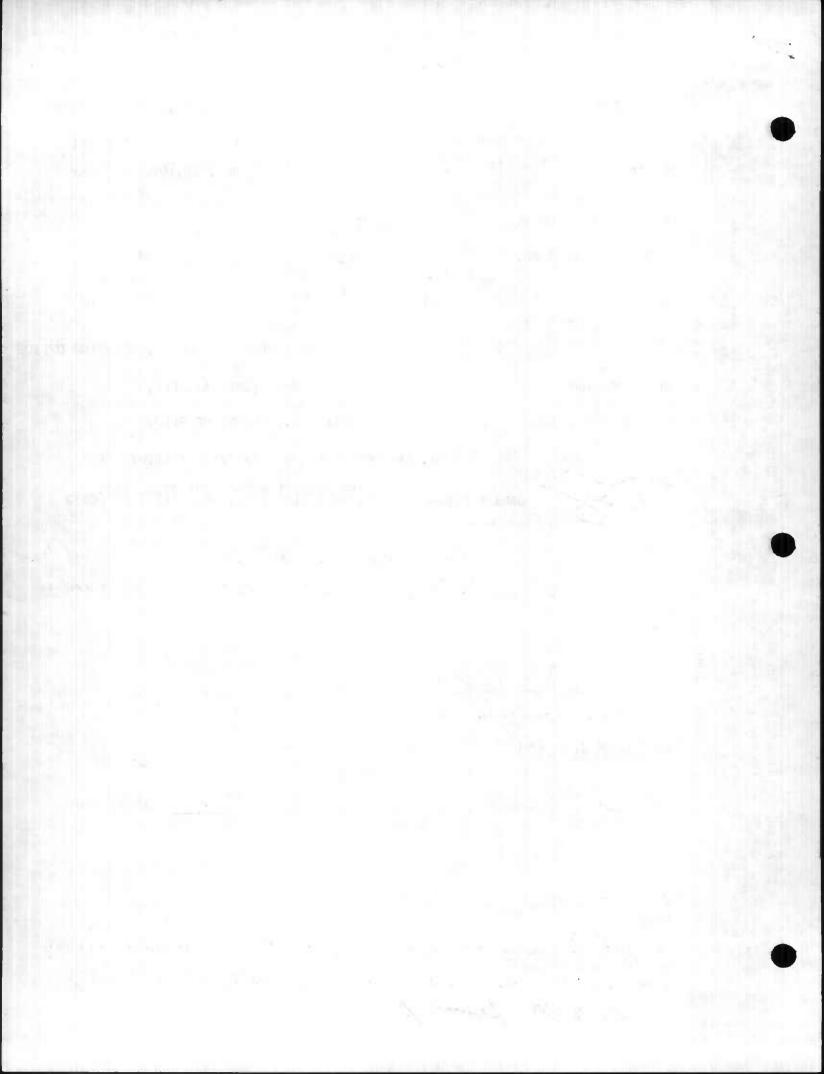
29d. Dale signed (Month, Day, Year)

1/5/1999



State of Maryland / Department of Health and Mental Hygiene Amend #26,1/13/99,BMW,Montg.Co per physician Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** STRUMPF JAN. 11, 1999 7:15AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner COUNTRY LIVING GROUP HOME FOR THE ELDERLY POOLESVILLE MONTGOMERY 6. Sex If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** Deys Months Hours 88 084-10-4119 AUG. 26,1910 Director NY Usual Residence of Decedant the Marylend 10e. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, it a Maxical Examinet numb be notified at 1 Yes 2 No Director MD MONTGOMERY **POOLESVILLE** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 15201 MONTEVIDEO RD. USA 20837 Funeral 12. Was Decedent Ever in U,S.
Amped Forces?
1 ☑ Yes 2 ☐ No
If Yas, Give
Year or Dates: WWI] Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Black, White, etc. 72 hours efter 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Baltimore, Maryland 21215-0020 2 3 X Widowad 4 □ Divorced WWII WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7: th end Mentel Hygiene. 7 is marked other than "n College (1-4or 5+) Elementary/Secondary (0-12) GOV'T. PRINTING OFFICE PROOF READER 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Be JULIUS STRUMPF ANNA (UNOBTAINABLE) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2.
Department of Health elimportant: If item 27 la any injury or other trat MARK STRUMPF / SON 17324 BUEHLER RD., OLNEY, MD 20832 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removel from State MT. LEBANON CEMETERY 1/12/99 ADELPHI, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Litensee EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, INC. MD 20852 DANIEL SIMONS 23a. Part 1. Enter the duesas or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart hallow. List only one causa on each line. Approximete Intarval Batween Onset and Death **Physician** /Medical Immediate Ceuse (Final ud des los disease or condition resulting in death) venticu Examiner Due to (or as a consequence of) Examiner vears Schemia physicien end the bunel-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that Initiated avants resulting in death) Last Due to (or as e consequance of) Box 68760 certificate be Physician/Medicai Due to (or as e consequence of): 98 use Po Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contribute to the cause of death? P.O. detached the 2 1 Yes 2 No 3 Probably 4 Unknown 6 10 vas culen direare Division of Vital Records, à 8 24b. Wera eutopsy findings eveileble prior to completion of ceuse of death? 24e. Wes en autopsy performed? Completed diasetes peen hes 1 Tyes 21 No 1 ☐ Yes 2 ☐ No 25. Wes cese raferred to medical examiner? Be 26. Place of Deeth (Check only prie) Group home Hospital: Other: 4 Nursing Home 6 Recidence 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funerel Dete of Injury (Month, Day Yeer) 27. Menner of Death 1. Watural 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend efter death Director: 28f. Location (Streat end Number or Rurel Route Number, City or Town, Stata) 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 | Homicide 24 hours to Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basts of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. Medical 29a. Cartifier (Check only one) To the I within 2 29d. Date signed (Month, Dey, Year) 29b. Signature d title of certifier 29c. Licanse number 30. Name and addrass of person who complated causa of death (Itam 23e) (Type, Print) GAITHERSBURG MELNICH RUSSELL AVE JOHN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 13 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month Dey Ellen H. Schildkamp January 8, 1999 3:00 PM 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Suburban Hospital Bethesda Montgomery Hours Min. 8. Dete of Birth (Month, Day, Year) Aug. 30, 1940 If Under 1 Year 9. Birthplace (Stete or Foreign Country) New York 5. Social Security Number 7. Age (In vrs. last birthday) 1 M 2 XF Months Deys 080-32-1720 58 Usuel Residence of Decedent 10c. City, Town or Location 10e State 10b. County 10d. Inside City Limits 1 X Yes 2 No Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4511 Dresden Street 20895 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Coliege (1-4or 5+) Elementery/Secondary (0-12) NTH Personnel Administration 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Francis X. Hickey Rose Marie Kettl 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) (husband) 4511 Dresden Street, Kensington, MD 20895 John R. Schildkamp 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Gate of Heaven Cemetery 1/12/99 Silver Spring, MD 22. Name end Address of Feelilly Francis J. Collins Funeral Home, Inc. 500 University Blvd. West 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service License 20901 Silver Spring, MD the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco usa contributs to the cause of death? t Yss 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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after death Director:

To the Hosp within 24 hor To the Fune completely fi

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Completed

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Certification:

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permit. Page Department of Important: If any injury or

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be liled within 72 hours after death with nent of Heelth end Mental Hygiene.
int: If item 27 is marked other then "naturel; or items 23a or inty or other treumatic svent, the Magical Examine must be a

Baltimore, Maryland 21215-0020

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Division of Vital Records,

Directo

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Completed

the Maryland

Examiner physician and s the buriel-trans Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lest Physician/Medical 88

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24a. Wes en eutopsy performed?

24b. Were eutopsy findings available prior to completion of cause of deeth?

1 ☐ Yes 2 ₺ No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25.	exeminer? 1 Yes 2 No
27	Manner of Deeth

1 Neturel 5 ☐ Pending investigetion 2 Accident 6 Could not be determined 3 Suicide

28a. Date of Injury (Month, Dey Year) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of Injury

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

4 Homlcide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

29b. Signature and title of certified

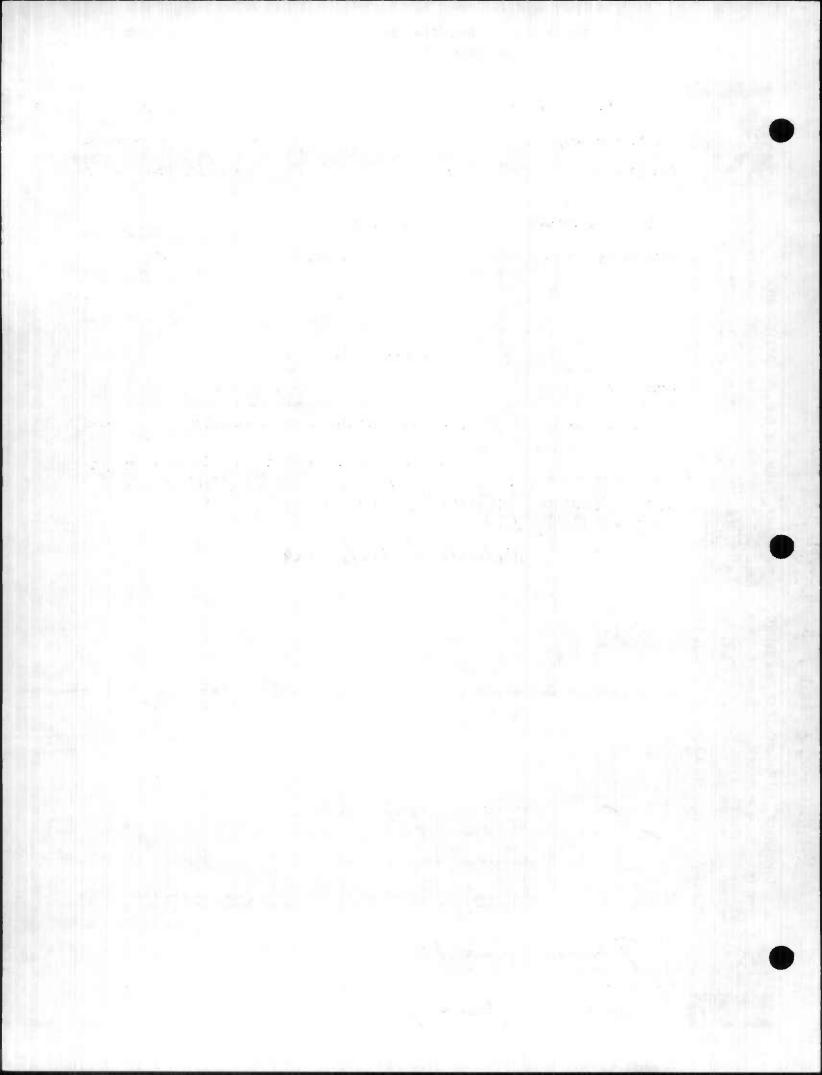
29d. Date signed (Month, Dey, Year)

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Frederick G. Barr, M.D., 5454 Wisconsin Avenue, Chevt CHase, MD 20815 31. Dete filed (Month, Pay, Year) JAN 1 1 1999

State Registrar

32. Registrer's Signature



		14.4	Ce	rtificat	e of I	Death			Reg.	No.		. 0	58
. Decedent's Name (First, Middle, Las	t)							2. Date of I	Death	Day	Year	3. Ti	me of Death
GEORGE JOHN SEKAS								JANUA	RY	8, 19		7:	45 A.M
a Facility Name (If not institution, give	street and num	nber)			4	b. City, To	wn, or L	ocation of De	eth	4c. Count	y of Death		
10523 TRUXTON ROAL						ADEL	PHI			PRINC	CE GE	ORGE	S
. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of E	Birth Ye	ar)	9. Birth	piace (S	tate or Foreig
579-32-7331	ØM 2□F	7	1 Yrs.	MONITIES	Days	riours	199101.	OCT. 2	3,	1927	OHI	O /	
Isuai Residence of Decedent													
0a. State 10b. County		10c. Cit	y, Town or Lo	ocation									ide City Limit
MARYLAND PRINCE	GEORGES	ADE	ELPHI									1	Yes 2000
0e. Street and Number				10f. Zip	Code				10g.	Citizen of	What Cou	intry?	
10523 TRUXTON ROAL				207	783				UN	ITED	STAT	ES	
1. Marital Status	12. Was Dece		,S. 13.	Was Deced	dent of H	ispanic Orl	gin? (Sp	pecify Yes or I o Rican, etc.)	Vo-		ca - Amer		an,
1 Never Married 2XXMarried	Armed For	2 No 1	946-				i, Puerio	o mican, etc.)			ack, White	, etc.	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da	8 1	947	1 🗆 Yes	2 XĮ No	Specify:				Speci	WHI	TE	
15. Decedent's Edi		-	16a. Dece	dent's Usua	al Occup	ation			168	. Kind of E	Business/In	ndustry	
(Specify only highest grad	de completed) College (1-	-40r 5+\	(Give	DO NOT us	se retired	du <i>ring</i> most d)	or won	KIII					
12	College (1-	-UI 3+)	MAIL	ER					N	EWSPA	PER I	INDU	STRY
7. Father's Name (First, Middle, Last)						18. Mothe	r's Nan	ne (First, Midd	-				
JOHN G. SEKAS						ртит	TRA	PAPPA	S				
19e. informent's Name/Relationship (T	vpe, Print)		19b. Maili	ing Address	s (Street			ral Route Nun		ity or Town	n, Stete. Z	ip Code)	
LITSA SEKAS - WIFE Oa. Method of Disposition		20b. F	Place of Disp			KUAD,	AD	ELPHI,		C. Location			ete
1 X Buriel 2 ☐ Cremation 3 ☐	Removal from S		ametery, cre	metory or o	other place	ca)	1		-				
4 ☐ Donation 5 ☐ Other (Specify)	PAR	KLAWN	MEMOR	TAT.	PARK	ካ	-12 - 99	RI	CKVI	LLE.	MAR'	YLAND
Part Enter the disease or compositions, or heart failure. List only of	Cations that or	ward the deat	1 1	2. Name ar .NES-R .800 N	nd Addre RINAI NEW H	ss of Facilit LDI FU HAMPSH	y JNER HIRE	AL HOM	E,	INC.		NG,]	
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21. Signature of Function Service Licent 22. Part 1. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	fications that earne cause on ea	RIC CAR	HI 11 h. Do not en	2. Name an NES-R 800 Noter the mod	nd Addre RINAI NEW H	ss of Facilit LDI FU HAMPSH	y JNER HIRE	AL HOM	E,	INC.	SPRI	Appro intervi Onset	MD 209 ximate el Between and Death
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State Registrar

Physician /Medical **Examiner**

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or flering 23s or 28s-1 show any injury or other traumatic event, the Wed call Examinat must be notified at any and a sorting the statement of the contract
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

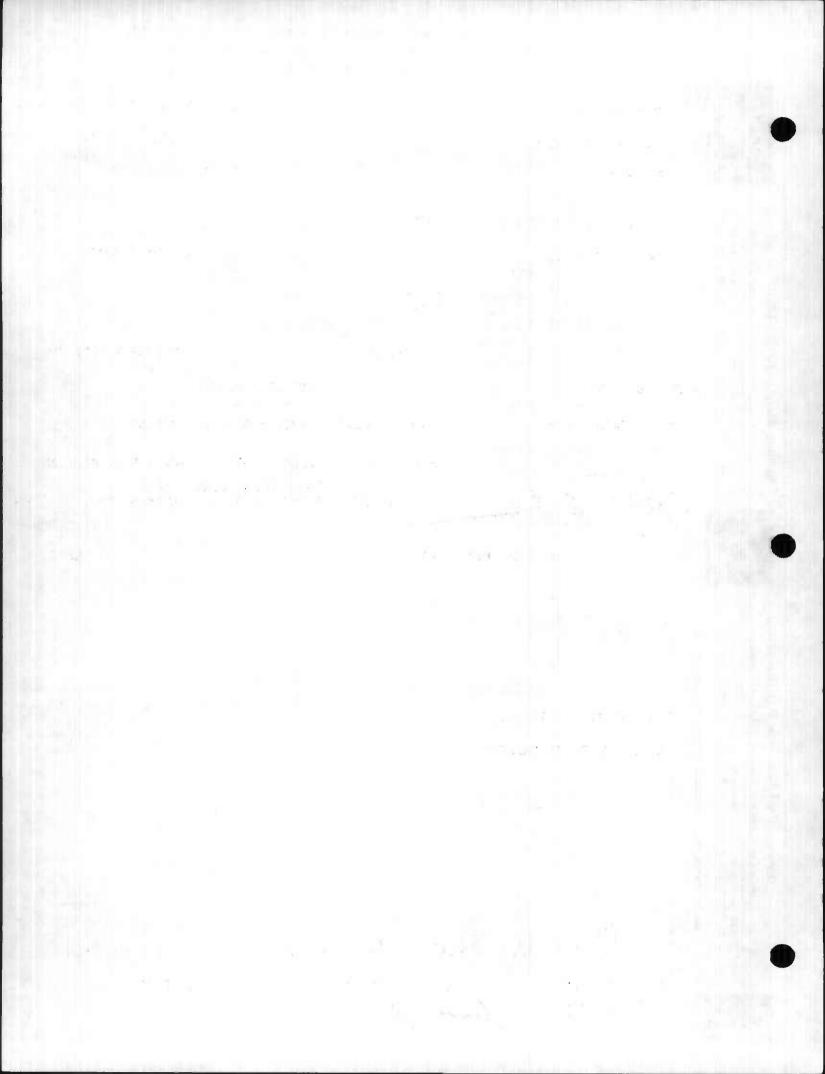
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

31. Dete filed (Month, Day, Year) JAN 13 1999

CHARLES M. BENNER, M.D., 32. Registrar's Signature

11251 LOCKWOOD DRIVE, SILVER SPRING, MD 20901 Sparks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3 Time of Death Month EDNA SHELTUN JANUARY 0435 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville MD Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. 1 (Alonth Day Year) 5. Social Security Number 9. Birthpleca (Stata or Foreign NEW YORK CITY 6 Sex 7. Aga (In yrs. last birthday) 1□ M 2⊠F Months 090-14-4074 78 Yrs. Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2(TYNo MARYLAND MONTGOMERY GAITHERSBURG 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9890 WASHINGTONIAN BLVD. 20878 #610 UNITED STATES 12. Was Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yas, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5-1-TEACHER EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meiden Sumema) ALEXANDER WEISS 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 10802 COOPERSMITH CT, N. POTOMAC, MD 20878 VICKI DE ANGELI DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation □ Removal from State 5 Other (Specify) 4 Donation MOUNT COMFORT CEMETERY ALEXANDRIA, VA 22. Name and Address of Facility
DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 or complications that aused he deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, list only one cause on each lin. of 1. Ententh Approximata Interval Between Onset and Deeth Immediate Cause Final structive Pulmonary Disease disease or condition resulting in death) Due to (or es e consequence of): Due to (or es a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1. Yes 2□ No 3 Probably 4 Unknown 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

6

238 death

or items

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permit. Pages 1 and 2 should be filed with Department of Health and Mentel Hygien important; if them 27 is marked other the any Injury or other treasment.

Directo

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Completed

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2

traumatic event, the Madical Examiner must be notified at

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

physician a 0 signed by I paga To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; t

Deed

certificate

The law requires that the death certificate be sweet

Box 68760,

P.0.

Records,

Division of Vital

Examiner Physician/Medical Be Completed by 2 Certification:

Sequentielly list conditions, if eny, laeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical 26. Place of Deeth (Check only one) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA 27. Mennar of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 28e. Date of Injury (Month, Dev Year) 5 Pending investigation 1. Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street end Numbar or Rurel Routa Number, City or Town, State) 28e. Pleca of Injury - At homa, farm, straet, factory, office bullding, etc. (Specify) 4 D Homicide tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 16220 Frederick Poxo Site 31. Dete filed (Month, Day, Year) **JAN 1 1** 1999

OMPL A BAll

29b. Signeture end title of certifier

213 32. Registrer's Signature

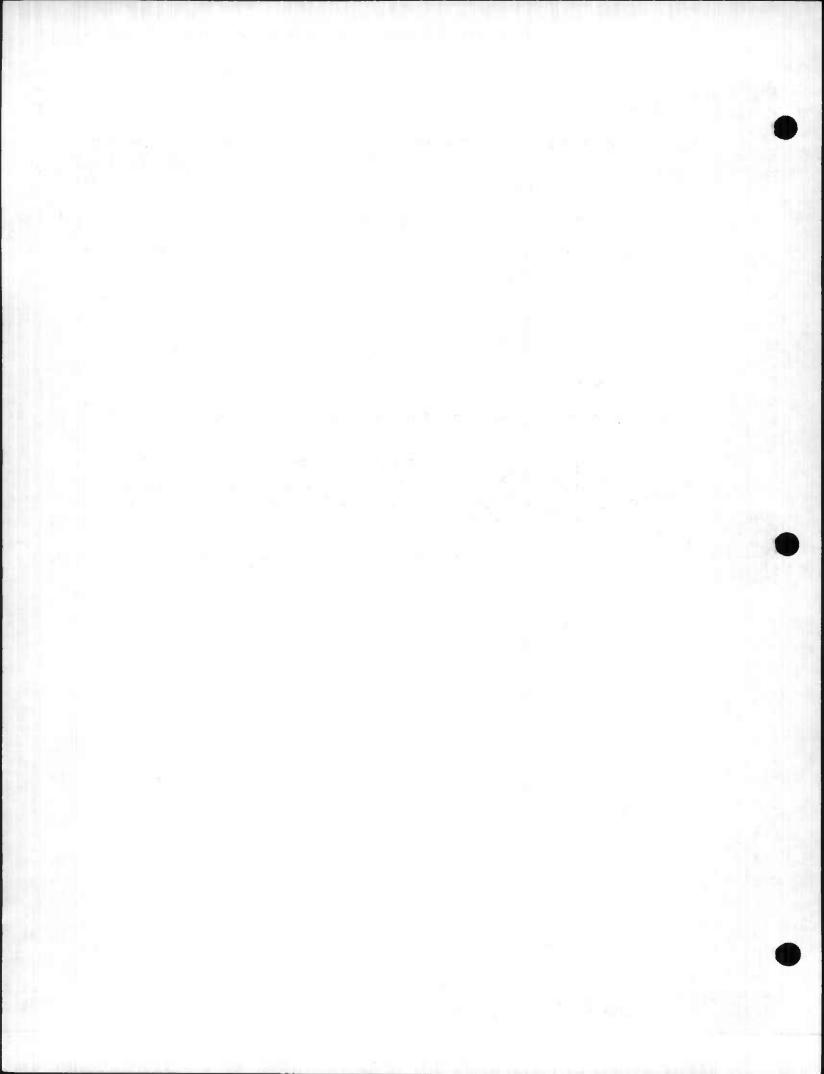
Gaithersburg

29c. License number

P 23317

29d. Date signed (Month, Dey, Year)

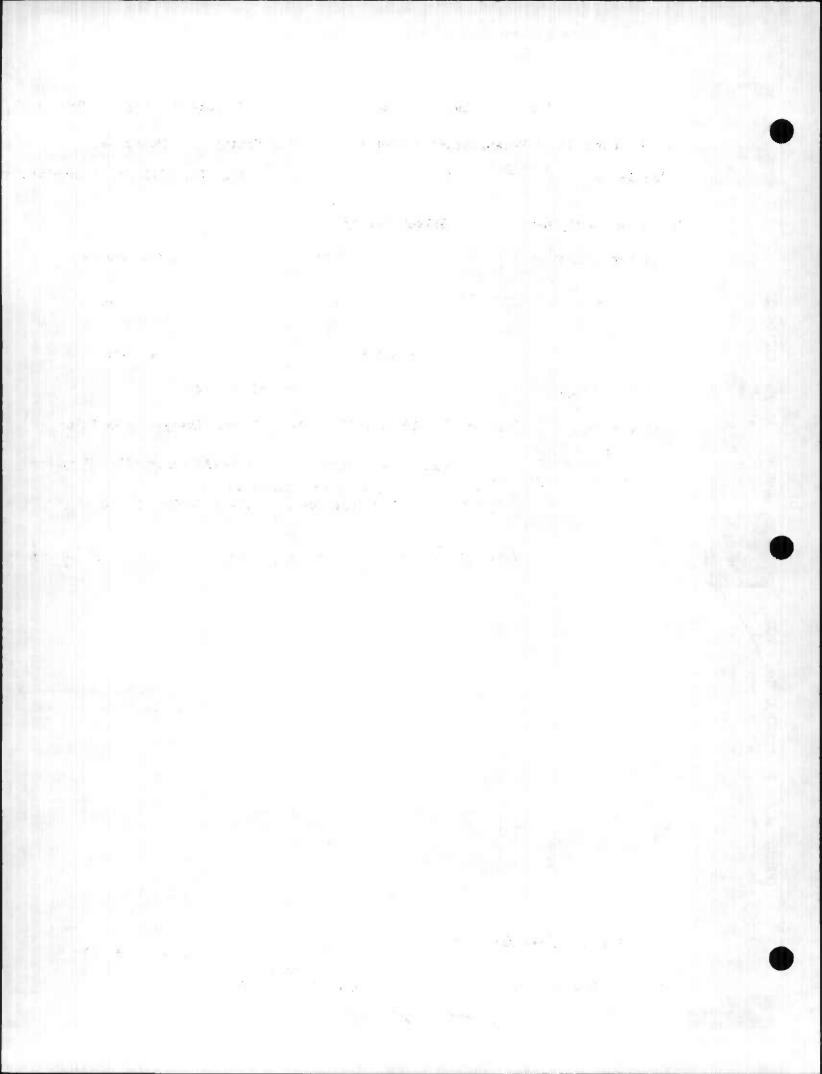
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 0 | 660

				Certific	ate of	Death	F	leg. No.	01000
	1. Decedent's Name (First, Middle, La.	st)	THE CO				2. Date of Dea Month		3. Time of De
Physician /Medical	E	Cva C	laire	Smit	th		January		10:20 A
Examiner	4a Facility Name (If not institution, give	e street and number))		4	b. City, Town, or	Location of Death	4c. County of	of Death
	Fairland Nursing	& Rehabil	itatio	n Center	r	Silver S	Spring	Monts	gomery
uneral	5. Social Security Number 6. S	ax 7. Ag	ga (In yrs. last		nder 1 Year	If Under 24 Hrs Hours Min	8. Date of Birth	Year)	Birthpleca (State or Fe Country)
irector	579-03-9782	□M 2\\ F	85	Yrs.	Liio Days	110013			North Caroli
3_	Usual Residence of Decedent 10a. State 10b. County		10c, City, T	own or Location					10d. Inside City L
Important: If them 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at pace. To Be Completed by Funeral Director	Automobile de la companya del companya del companya de la companya								1 ☐ Yes 25
or 28a-1 s be nothled	Maryland Montgom	ery	Sil	ver Spri	. Zip Code			I0a. Citizen of W	•
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Tun In	1 Never Married 2 Married	Armad Forces	7	If Yes,	specify Cuba	n, Mexican, Pue	rto Ricen, etc.)		k, Whita, atc.
y S	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	140	1□ Ya	as 21 No	Specify:		Specify:	White
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Diet on	(Specify only highest gra	de completed)	5	(Give kind o	f work done of Tuse retired	during most of wo	orking		
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aric every To B	Albert Thompson	n				Abigai	1 Wilson	1	
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27 is trait	Invadia C Dank	(daught	ror)	19267 R	olling	Hills	Drive. Cı	lneper.	VA 22701
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6 8							24a Was	an autopsy	24b. Were eutopsy find
sate has been si page 2 should I							perfo	med?	available prior to completion of caus
8 cl 0									of death?
cate . pag							1 🗆 Y	es 2X No	1 ☐ Yes 🌠 No
s certificate he director, page To Be Com	25. Was cese referred to medicel examiner?	Hospital:			Oth		eath (Check only o		
this or ral dire	1 ☐ Yes 2 📉 No		ent 2 ER		DOA Oth	44M Nursing	Home 5 Resid		
funer funer	27. Menner of Death 1 ☑Netural 5 ☐ Pending	28e. Date of Inju (Month, De	ay Year) 28	b. Time of Injury	28c. Injur		28d. Describe h	ow injury occurre	ed
al Director: After t led in by the funers Certification:	2 Accident investigation 3 Sulcide 6 Could not b			M		Yes 2 □ No			
irect n by	4 Homicide determined	286. Place of in	jury - At home tc. <i>(Specify)</i>	e, farm, street, fa	ctory, office		281. Location (S City or Tow		er or Rural Route Number
S S									
		velclan. To the heet	of my knowle	dge, death occur	rred at the tir	ne, date and pled	ce, and due to the courred at the time,	cause(s) end mei date and place, a	nner as stated. and due to the ceuse(s)
ely f	(Check only 2 Medical Exam	niner: On the basis of							
the Funer npletely fill	(Check only 2 Medical Examone)	niner: On the basis of and manner st	tated.					and Data stee	
To the Funeral Director. After this completely filled in by the funeral Medical Certification:	(Check only 2 Medical Examone) 29b. Signature and titla of certifiar	niner: On the basis of and manner st	tated.		29c. Licens			29d. Date signed	(Month, Day, Year)
To the Fune completely fi	(Check only 2 Medical Examone)	niner: On the basis of and manner st	tated.		29c. Licens			-	
To the Fune completely fi	(Check only 2 Medical Examone) 29b. Signature and titla of certifiar	niner: On the basis of and manner st	u.O.		29c. Licens	a number		-	(Month, Day, Year)
To the Function of the Functio	(Check only 2 Medical Examone) 29b. Signature and titla of certifiar Bulleur K	completed cause of	u.O.		29c. Licens	6716 Cherry I		-	(Month, Day, Year)

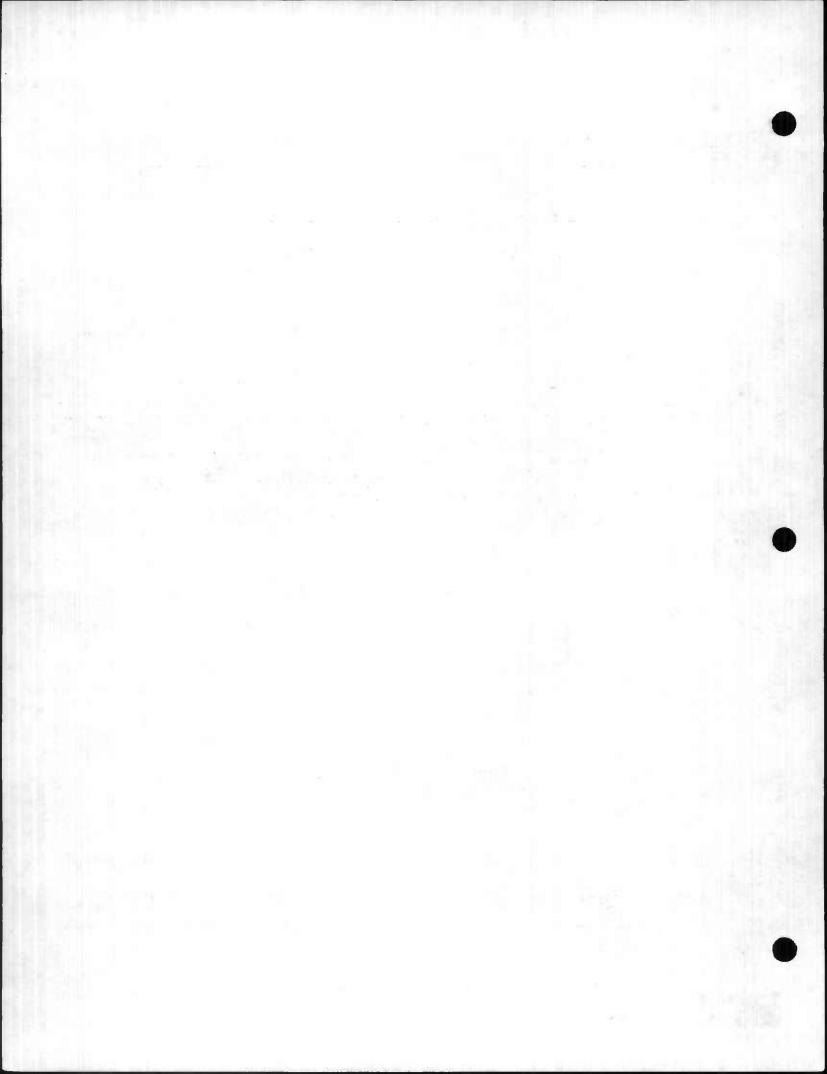


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				Ce	rtificate	of l	Death	Я	eg. No.		
	6	1. Decedent's Name (First, Middle, La	nst)	THE PERSON				2. Date of Dea Month	th Day	Yaar	3. Time of Deeth
	Physician /Medical	Percy Leo Smith						Jan 8,		F GIGIT	12:25am
	Examiner	4a Facility Name (If not institution, gir	ve street and number)			4	b. City, Town, or	Location of Death	4c. County	of Death	
		Holy Cross Hospi					Silver S		Montg		
	Funeral Director	214-30-1591	Sex 7. Age (I 1⊠ M 2□ F 6	n yrs. last birthday, Yrs.	Months 1	Year Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day Dec. 31	,1931	9. Birthp Coun Mai	place (State or Foreign otry) ryland
	Pu Bu	Usual Residence of Decedent 10a. Stata 10b. County	110	Dc. City, Town or L	ocation					1	0d. Inside City Limits
	f aho	MD Montgo		Kensi							Yes 2□No
	vith the Mail t or 28a-f all be notified Director	10e. Street and Number	211027	RCIIDI	10f. Zip C	ode		11	0g. Citizen of \	What Coun	itry?
	Sa vith	3903 Hampde	en Street				895			S.A.	-
21215-0020	hours after death with the Maryland urel', or theme 23s or 28s-f show a Exercical must be notified at cd by Funeral Director	11. Marital Status 1 Never Merried 2 Married 32 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2€No If Yes, Give Year or Dates:		Wes Deceder If Yes, specify			pecify Yes or No- to Rican, etc.)	Blac	e - Americ ck, White, Bla	etc.
2-0	72 hours natural', dical Ex-	15. Decedent's E		16a. Dece	dent's Usual (Occupi	ation furing most of wo	deina	16b. Kind of B	usiness/Ind	dustry
21	ed within 72 ho vgiene. er then "neturn t, the medical Completed	(Specify only highest gri	College (1-4or 5+)	life.	DO NOT use	retired)	TANIS.		9	ery Co.
	Hygien the	6th		C	ustod:	iar			Scho		
ng	A E D A	17. Father's Name (First, Middle, Last Percy Smit						me (First, Middle, i adys Ja		10)	
7	Mental Mental Marked of marked or ma			1							
, Maryland	and 2 ah saith and 1 27 is m	19a. Informant's Neme/Relationship Lisa Smith Jo	hnson (Da	ughter)	415	Mu		anch Rd			20878 rsburg,MD
Baltimore	Pages 1 ment of He ant: If Nen ury or oth	20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	20b. Place of Dispo cemetery, cre Gate O	metory or other	er plec			20c. Location - Silve		own, Stata pring, MD
Balt	Departi Departi Importa eny Inju	21. Signatury of Funerel Service Life	Mouse	10,		EN	FUNERA FUNERA E, MD	L HOME,	P.A.		
	21-1-1-1	23a. Part1. Enter modisease, or conshock, or heart failure. List only	plications that caused the one cause on each line.				-		est,		Approximata Interval Between Onset and Death
	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	. Hyp	oxia						0	2 days
	5		D. 114	e to (or es a conse	quence of):	-	1.1.00				2 41088
	axecuted in and ial-transit Examiner	Sequentially list conditions	b. YVVVI	e to (or as a conse	quence of):		13562	W .		10	~ Uveres
ó	an a	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	OLLOM	which	3016	01	d re	diag	TOU		2 MIRIN
68760,	ifficate be assected g physician and as the burial-transit ledical Examir	Cause (Disease or injury that initiated events resulting in death) Last	C. Due	e to (or as a consec	quence (pf):		ce 14				- (10000)
			d								
m	death e atte d for	Pert II. Other significant conditions of	contributing to death but n	ot resulting in the u	Inderiving cau	se giv	en in Part I.	23b. Did to	obacco use co	ntribute 10	The cause of death?
P.0	requires that the death cert wen signed by the attendin hould be detached for usa eted by Physician/W	Hodekins	Swear	ul				1 🗆 Y	20	3 ☐ Prof	
Vital Records,	been should					X		24a. Wes a		av	ere autopsy findings ailable prior to mpletion of cause death?
æ	The is page of the is	S What has a con-						1 U Y	es 2 No		Yes 200
ta	ician: The lav certificate has rector, page 2 Be Comp	25. Was case referred to medical					26. Place of De	eth (Check only or			
>	F 6 5	axaminer?	Hospitel: 1 Manpatient	2 ER/Outpatie	nt 3 DOA	Oth	er: 4 Nursing h	Home 5 ☐ Resid	ence 6 Oth	er (Specif	וע
lon of	Afre fund	27. Manner of Death 1 Daturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	M 280	Unjun Work	vat ⟨? Yes 2□No	28d. Describe h	ow injury occur	red	
á	tal or Attending P rs after death. at Director: After t ied in by the funant Certification:	3 Suicide 6 Could not be determined			reet, fectory, o	office		28f. Location (S City or Tow		ber or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completally filled in by the funeral Medical Certification: 7		nysician: To the best of m miner: On the besis of ex and manner stated	amination and/or in							
	Withir Comp	29b. Signature and title of certifier	1		29c. L	icense	number	2	9d. Date signe	d (Month,	Dey, Year)
	11)	* Caldus	rochle	~	1	55	2 38	/	Jan 8,1	1999	
	10	30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)						
		Robyn D.Anderson	MD 1500 f	orest Gle	n Rd S	ilv	er Sprin	ng Md 209	10		
	State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1						
	Registrar	IAN 1 9 19	44 Denew	17	Ann	· W.	/				

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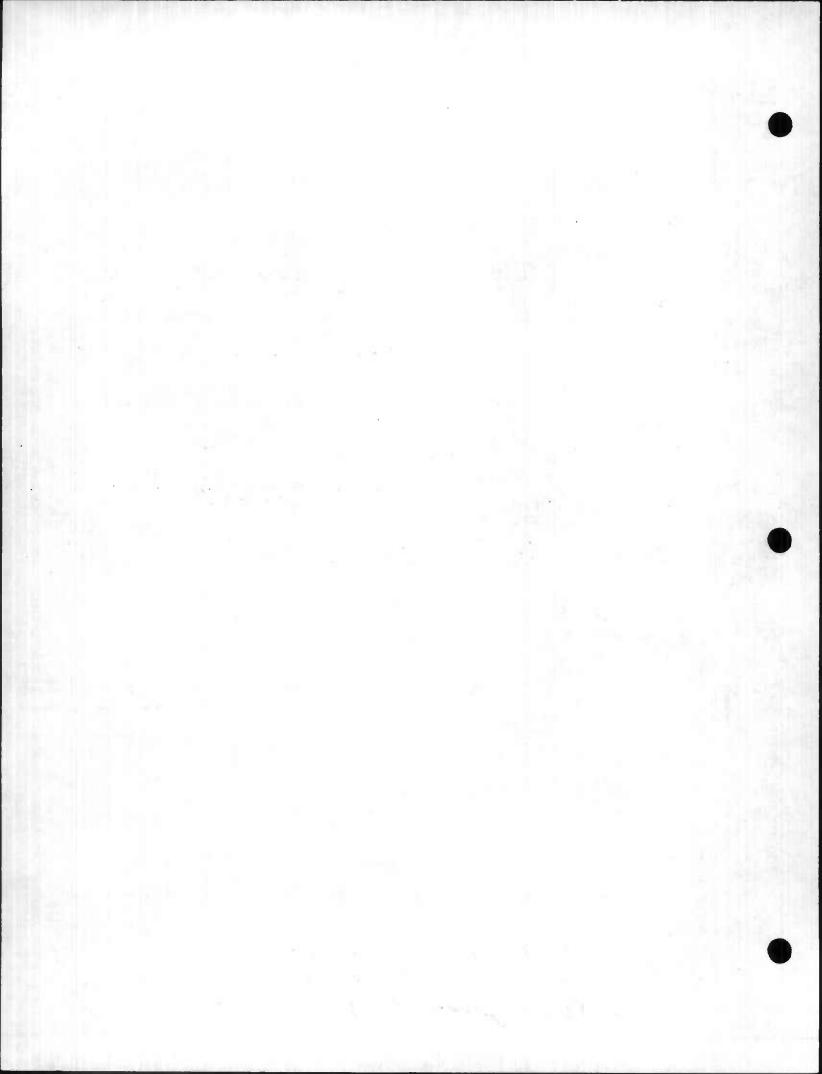


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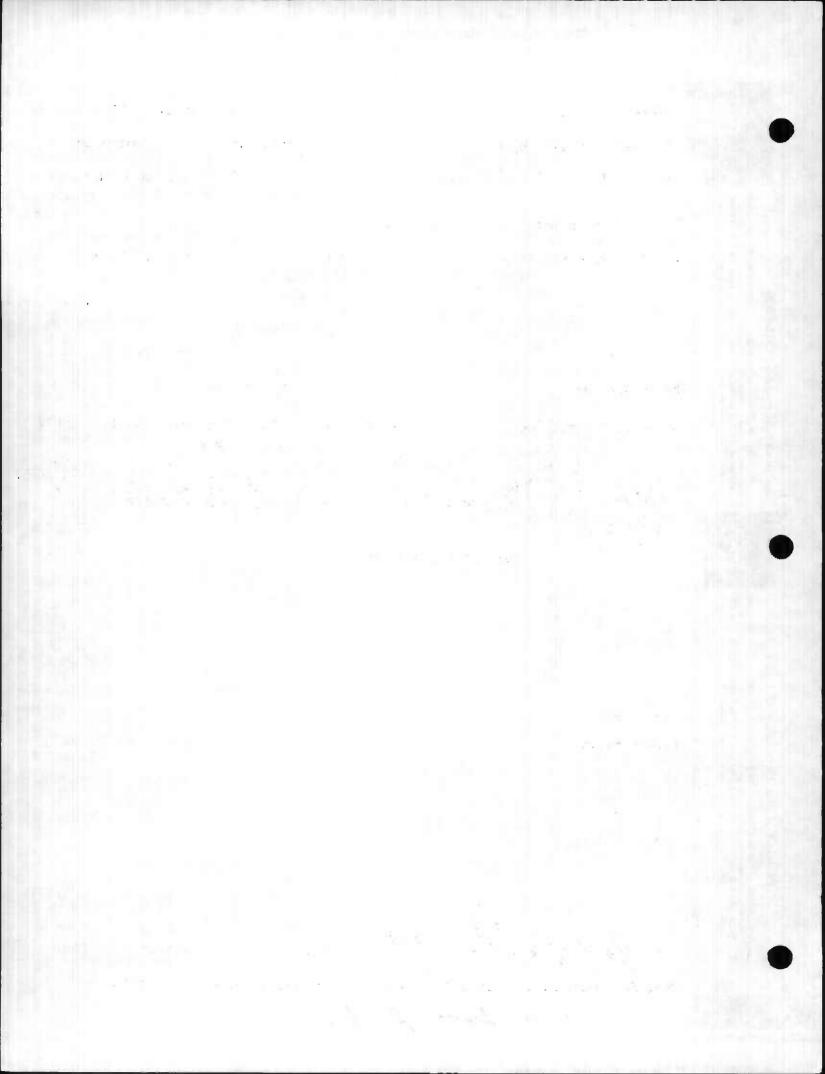
hysician	1. Decedent's Name (First, Middle, Last)			Death	2. Date of Dea			3. Time of Death
	Rosalie F.		Smith			January	12, 199	Year 99	4:40 AM
/Medical xaminer	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or I				
A BITTITIC	Althea Woodland Nu	ursing Home	e	- 1110	Silver S	Spring	Montg	gomer	y
neral	Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Yeer Months Days	If Under 24 Hrs.	8. Date of Birt (Month, Day Aug. 8,	h v Year)	9. Birthpi	lace (State or Foreig
ector	210-44-3703]M 2∏F	90 Yrs.	ino and	110010	Aug. 8,	1908	Wash	ington, I
100	Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or Lo	ocation				11	0d. Inside City Limit
- P									1 ☐ Yes 2 ☑ N
be notified Director	MD Montgo	omery	Silver S	10f. Zip Code			10g. Citizen of W	hat Coun	trv?
D P	10212 Haywood Driv	7e		101. 2.10 0000	20902		US		.,,
iner must be notified at Funeral Director	11. Maritel Status	12. Wes Decedent Ev	rer in U,S. 13. \	Was Decedent of	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		- America	an Indian,
by Fur	1 Never Married 2 Merried 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🖾 No		Rican, etc.)	Specify:	c, White, o Wh	etc. ite
	15. Decedent's Edu	cation	16a. Deced	dent's Usual Occu	pation		16b. Kind of Bus	siness/Ind	lustry
c, the Medical	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	pation during most of world)	king			
all lo	12	Conege (1-401 5+)	Manag	gement Sp	ecialist		Federa1	Gove	rnment
Be G	17. Father's Neme (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumeme	e)	
To	Walter Scott Smith	n			1	Mary Smi	th		
un e	19e. informant's Name/Relationship (T)				t and Number or Ru				
2 4	Elaine Downs	(daughte	er) 1618 20b. Place of Dispo		Avenue, 1		_	20851	
0 0	20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ F	temovel from Stete	cemetery, cren	matory or other pla		1/15799	20c. Location - (1-1-4	
dury	4 ☐ Donation 5 ☐ Other (Specify)	/			nal Cemeter	*	Suitland		
my in	21. Signature of Suneral Service Licegs	0////			ess of Facility Fra 500 Un:				eral
	foot Life	neth	LS St	Llver Spr	ring, MD	20901			
	23a. Bert1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the ne ceuse on each line.	ne death. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory ar	rest,	- 1	Approximate interval Between Onset and Death
ician dical	Immediate Cause (Final	() A	0-	010	L				
niner	disease or condition resulting in death)	Cloute W			arelion			1	3 wour
ē		Di	ue to (or as e conseq	quence of):				1	
ial-transit Examiner		D	ue to (or es a conseq	unage of				- 1	
Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events		de to to es a conseq	juenca ory.					
s the bunal-transit	Ceuse (Disease or injury that initieted events	D	ue to (or es a conseq	uence of):					
	resulting in death) Last							i	
ary and		1						1	
5 5		tributing to death but	not resulting in the un	nderlying cause gi	iven in Part I.	23b. Did 1	obacco use con	tribute to	the cause of deal
9 9	Part II. Other algnificant conditions cor						. 3	2 Deck	bably 4 Unknown
Physi	Part II. Other algorificant conditions con					10	Yes 2 No	3 Proc	
be detached for use I by Physician/M	Part II. Other eignificant conditions cor						•		an autonou findina
hould be detached	Part II. Other significant conditions cor					24a. Was	an autopsy med?	24b. We	silable prior to
e 2 should be detached mpleted by Physi	Part II. Other significant conditions cor					24a. Was	an autopsy	24b. We	ere autopsy finding aliable prior to mpletion of cause death?
Completed by Physic	Part II. Other significant conditions cor					24a. Was	an autopsy	24b. We ave cor	milable prior to
centinger has been signed by the rector, page 2 should be detached. Be Completed by Physic	25. Was case referred to medical axaminer?	fosoital:			26. Place of Dea	24a. Was perfo	an autopsy med? /es 20(No	24b. We ave cor of c	allable prior to mpletion of cause death?
ral director, page 2 should TO Be Completed	25. Was case referred to medical axaminer?		2 ☐ ER/Outpatien	t 3LI DOA	her: 4 Nursing H	24a. Was perfo	an autopsy rmed? /es 20(No	24b. We ave con of a	allable prior to mpletion of cause death?
	25. Was case referred to medical axaminer? 1 Yes 2 2000 27. Manner of Death 1 O Natural 5 Pending	fospital: 1 ☐ Inpatient 28a. Dete of Injury (Month, Day)	28b. Time of	28c. Inju	her: 4 Nursing H	24a. Was perfo	an autopsy med? /es 20(No	24b. We ave con of a	mpletion of cause death? Yes 2 No
	25. Was case referred to medical axaminer? 1 Yes 2 2000	28a. Dete of Injury (Month, Day 1	28b. Time of injury	M 1 C	her: 4 Nursing H iry at ork?	24a. Was perfo	an sutopsy med? (es 20 No ne) Jence 6 Othe now Injury occurre	24b. We ava	silable prior to moletion of cause death? Yes 2 No
	25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Dete of Injury (Month, Day) 28e. Place of Injury building, etc.	29b. Time of Injury y - At home, farm, str. (Specify)	M 28c. Inju	her: 4 X Nursing H iny at ink?] Yes 2 □ No	24a. Was perfo	an sutopsy med? (es 20 No ne) Jence 6 Othe now Injury occurred.	24b. We say cor of cor of cor (Specify and or Rura	allable prior to moletion of cause death? Yes 2 No
	25. Was case referred to medical axaminer? 1	28a. Dete of Injury (Month, Day) 28e. Place of Injury building, etc.	28b. Time of injury - At home, farm, str. (Specify) my knowledge, deeth kaminetion end/or inv	M 28c. Inju Wc M 1 [her: 4 Nursing H iny at ink?] Yes 2 No ime, date and place	24a. Was perfo	an autopsy med? (es 20 No ne) dence 6 Other now Injury occurred and Number on, State)	24b. We ave cor of a second of	allable prior to moletion of cause death? Yes 2 No No No Route Number,
	25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phys	28a. Dete of Injury (Month, Day) 28e. Place of Injury building, etc.	28b. Time of injury - At home, farm, str. (Specify) my knowledge, deeth kaminetion end/or inv	M 28c. Inju Wc M 1 [her: 4 Nursing H	24a. Was perfo	an autopsy med? (es 20 No ne) dence 6 Other now Injury occurred and Number on, State)	24b. We ave corrol of a second	islable prior to moletion of cause death? Yes 2 No No Route Number, ated. the cause(s)
pletely filled in by the funeral edical Certification:	25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one)	28a. Dete of Injury (Month, Day) 28e. Place of Injury building, etc.	28b. Time of injury - At home, farm, str. (Specify) my knowledge, deeth kaminetion end/or inv	an occurred at the tivestigetion, in my	her: 4 Nursing H	24a. Was perfo	an autopsy med? (es 20 No ne) Jence 6 Other now Injury occurred and Number (in State) cause(s) and mandate end place, and 29d Date signed	24b. We ave corrol of a second	islable prior to moletion of cause death? Yes 2 No No Route Number, ated. the cause(s)
	25. Was case referred to medical axaminer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one)	28a. Dete of Injury (Month, Day) 28e. Place of Injury building, etc. (string) alcian: To the best of ener: On the besis of eand manner state	Year) 28b. Time of injury - At home, farm, str. (Specify) my knowledge, deeth xaminetion end/or invid.	an occurred at the tivestigetion, in my case.	her: 4 Nursing H	24a. Was perfo	an autopsy med? Yes 2 No ne) Jence 6 Other now injury occurred and Number (No. State) cause(s) and mandate end place, a	24b. We ave corrol of a second	allable prior to moletion of cause death? Yes 2 No No Route Number, ated. the cause(s)

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				Cer	tificate of	Death		Reg. No.		0.71		
n	Decedent's Name (First, Middle,	Last)					2. Dale of De Month	eath Day	Year	3. Time of Death		
1	James Sprouse						Januar	ry 11, 1	999	9:23 AM		
r	4a Facility Name (If not institution,	give street and nun	nbar)			4b. City, Town, or Lo	ocation of Deat	th 4c. County	of Death			
ı	Rockville Nursi	ng Home				Rockvil			ntgo	mery		
1		. Sex	7. Aga (In yrs.	last birthday)	If Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Bi (Month, Di	rth av. Year)	9. Birth	placa (State or Foreign ntry)		
	718-01-9518	1 M 2 □ F	88	Yrs.	Michaile Days	110010	October	21, 1910				
	Usuel Residence of Decedent		140.00	_								
ı	10a. Slale 10b. County		10c. Cit	ty, Town or Loc	cation					10d. Insida City Limits		
	Maryland Montgom	ery	Ве	thesda						1 ☐ Yes 21 No		
	10e. Streel and Number				10f. Zip Code			10g. Citizan of	Whel Cou	nlry?		
	10125 Crestberry	Place			2081	7		United	State	es		
	11. Marital Status	12. Was Dece	dent Ever in U	,S. 13. V	Ves Decedent of I	Hispanic Origin? (Sp	ecify Yes or No			cen Indian,		
	1 Navar Married 2 Married		2 🔯 No			an, Mexicen, Puerto	Hicen, etc.)		ck, White	, etc.		
	3 ☑ Widowed 4 ☐ Divorced	If Yas, Give		1	☐ Yas 2 No	Specify:		Specif	y: 1	White		
	15. Decedent's			16a. Deced	ent's Usuai Occup	pation		16b. Kind of B	usiness/Ir	ndustry		
	(Specify only highest		Apr F. \	(Give I	kind of work done OO NOT use retire	during most of work d)	ing					
	Elementery/Secondary (0-12)	College (1	-401 3+)	Cra	ne Opera	tor		Railro	ad			
	17. Father's Name (First, Middle, La	st)			1	18. Mother's Name	e (First, Middle	e, Meiden Suman	ne)			
	Peter Sprouse					Mary Ro	salta					
	19e. Informent's Name/Reletionship	(Type Print)		19h Mallin	a Address (Street	end Number or Run		her City or Town	State 7	n Code)		
	James P. Sprouse											
		nd 20817										
	20a. Method of Disposition 20b. Place of Disposition (Neme of cematery, crematory or other place) January 13, Date 20c. Location - City 20c. Location - Cit											
	4 □ Donation 5 □ Other (Spe				ng, Maryla							
	4 Donation 5 Other (Specify) 21. Signature of Funeral State Donate 22. Nama and Addrass of Facility Robert A. Pumphrey Rockville, Inc. 300 West Montgomer											
	Maxim 1											
	23a Part Enter the disease, or ex	Rockville, Maryland 20850-2805 pplications that caused the death. Do not effer the mode of dying, such as cerdiac or respiratory arrest, Approxim								Approximate		
23a Part Ester the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate Interval Between Onset and Death Onset and Death												
	Immediate Cause (Final	D1.		s Disea	1.19.62				!	Voore		
	disease or condition resulting in deeth)	a. Park	Years									
			Due to (or as a consequ	uence of):							
		b										
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or Injury		Due to (d	or as a consequ	uence of):							
	cause (Disease or Injury	c							1			
	that initiated events resulting in deeth) Last		Dua lo (d	or as a consequ	uance of):				į			
		d										
	Part II. Other significant conditions	contributing to de	ath but not ras	ulting in the un	darlying ceuse gi	ven in Part I.	23b. Did	tobecco use co	ntribute	to the cause of death		
	Dementia						1	Yes 2 No	3 Pro	obably 4 Unknow		
	Demonta											
	Hypertension							s en eutopsy formed?	a	Vere autopsy findings vallable prior to		
							, ,		0	ompletion of cause f death?		
							1 🗆	Yes 25 No	1	□Yas 2□No		
	25. Was case referred to medical					26. Place of Deel			,			
-	examiner?	Hospital:		15010-1	Ot DOA Ot	her			(Cana	26.1		
	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	28e. Date o		ER/Outpatien	1 3LI DOA	4 Mursing Ho		sidence 8 DOtl		ny)		
	1 ⊠ Natural 5 ☐ Pending	(Monti	h, Day Year)	Injury		ry et ork?] Yes 2 □ No	200. 00000					
	2 ☐ Accident investiga: 3 ☐ Suicide 6 ☐ Could no	ho	-41-7 A15-				29f Location	/Street and Num	har or Du	ral Route Number,		
	4 ☐ Homicide determine	286. Place	ng, etc. (Special	ome, tarm, stre	eel, factory, office			own, State)	ber or nu	rai riobie rediliber,		
	(Check only 2 Medical Ex	aminer: On the ba	sis of examina			ime, date and place, opinion, death occur						
	orne)	and mann	er stated.					and Detection	4 /4 / 44	S Manal		
	29b. Signature and title of certifier	All	1	MIM	29c. Licen			29d. Data signo				
	1 /red of	/eh	-	////	D	20516		January	11,	1999		
	30. Name and address of person wh	o completed ceus	e of death (Iter	m 23a) (Type, I	Print)							
	Joel Schulman, N	I.D. 941	0 01d	Georget	own Road	l, Betheso	la, Mar	yland 20	0814			
			egistrer's Sign					•				
	31. Dete filed (Month, Dey, Year)	32. FR	adistini 2 Sidili									
	JAN 12		egistier's Signi		Loon							



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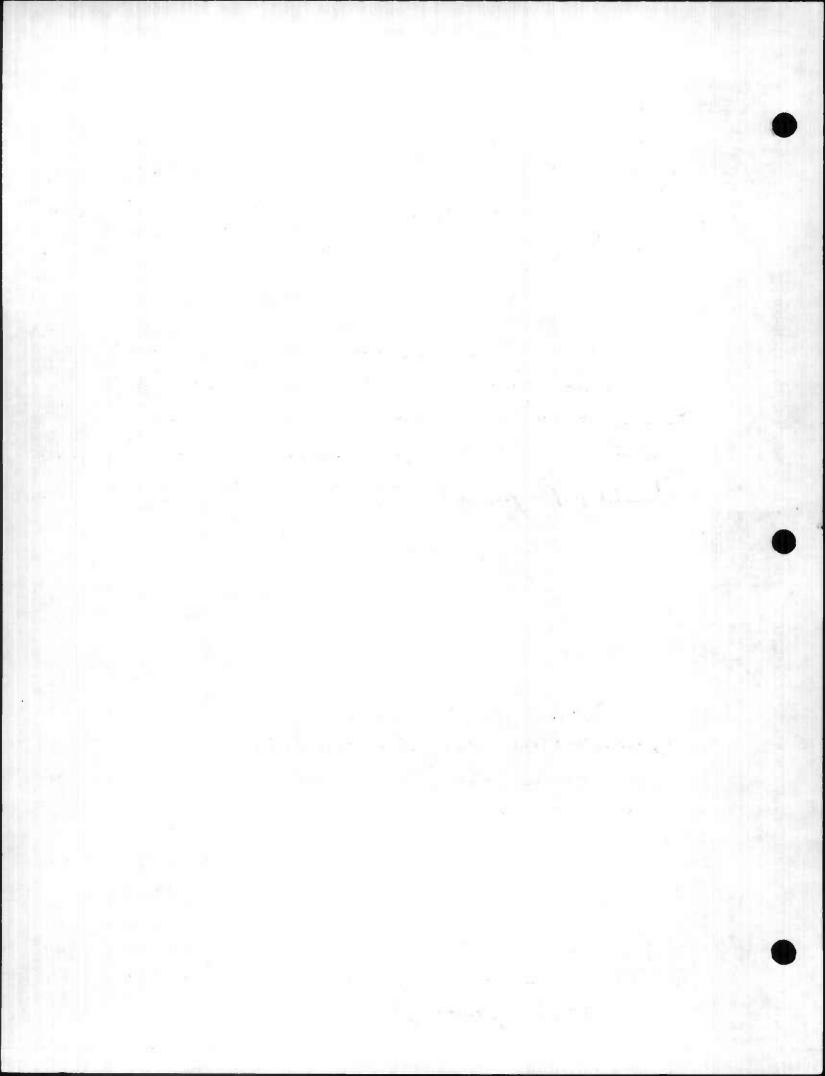
				Cer	tificate o	of Death		Reg. No.			
Physician /Medical	1. Decedent's Nama (First, M DOROTHY K.						2. Data of Da JANUAR) Š ^{aar}	3. Tima of Death 9:10 AM	
Examiner	4a Facility Nama (If not Instit 15101 GLADE I		number)			4b. City, Town, or SILVER	Location of Death		of Death NTGON	MERY	
Funeral Director	5. Social Security Number 578 18 4972	6. Sax 1 □ M 2 万 F	7. Aga (In yrs 82	last birthday) Yrs.	If Under 1 Y	aar if Undar 24 Hrs. ays Hours Min.	8. Date of Bir Month, Da DEC 8	1.916	9. Birthpl Count	laca (Stata or Foraign DE	
tal Hygiene. d other than "natural", or items 23s or 28s-f show event, the Marical Exeminer maint be notified at the Completed by Funeral Director	Usuel Residence of Deceden 10a. Stata 10b. Cou		10c. C	ity. Town or Lo	cation				10	0d. Insida City Limits	
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be nett	10e. Street and Number 15101 GLADE I				10f. Zip Coo			10g. Citizan of V	What Count		
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the even	JULIUS WEIMA							MILLMAN			
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Importment of nearing and wortal hygiene. Important if them 27 is marked other than once. To Be Compl	20a. Method of Disposition 1 № Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe	on 3. Hemoval fro	m State	Place of Dispo camatery, cran	natory or othar	placa)	Data /12/99	20c. Location -			
imports any inju	21. Signature of Funeral Sen	Klike	mar	DA	ANZANSK	ddrass of Facility Y-GOLDBERG KVILLE PIK	E. ROCK	VILLE MI			
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g physician and as the burial-transit	Due to (or as e consequenca of):										
0100	that initiated evants rasulting in death) Last	d	Dua to (or as a consaq	uanca of):						
by the seched	Part II. Other significant con		death but not ra	sulting in the ur	ndariying caus	a givan In Part I.				the cause of death?	
10 00 D	LUNG CANCER	PHOMA					24a. Was	an autopsy	24b. Wa	are autopsy findings ailabla prior to	
sctor, page 2 should Be Completed	20110 01210211							ormed?	of o	mplation of causa death?	
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his certi	axaminar?	Hospital:	☐Inpatiant 2□] ER/Outpetien	* 3□ DOA	Othar:	eth (Check only		ar (Snacih	vl	
2 60	27. Manner of Death 1 Watural 5 □ Pe	28a. De	te of Injury onth, Dey Year)	28b. Time of Injury	28c.	Injury at Work?		how injury occur		,	
를 들는 등	3 Sulcida 6 Co	uld not be tarmined 28e. Pla	281. Location (City or To	(Street and Numi wn, Stata)	ber or Rura	il Routa Number,					
within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier 1 Certifier (Check only one) 1 Medi	cal Examiner: On the	ha bast of my kn basis of axamin annar stated.	owledga, daath etion end/or inv	occurred at three stigation, in a	na tima, deta and place my opinion, deeth occu	a, end dua to tha urred at tha tima,	causa(s) and m , data and placa,	annar as st end due to	eted. tha cause(s)	
8 4 €	29b. Signatura and titla of bei	tyl	_ ~	מיר		cansa number			signed (Month, Day, Year) ARY 11 1999		
2	30. Nema and address of per JOSEPH KAPLA				Print)			20832			
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State of Maryland / Department of Health and Mental Hygiene O O

					rtificate of	Death	R	eg. No.	U	6001	
	Physician	1. Decedent's Nama (First, Middla, Last	CAR S	STOVES			2. Data of Dear	Day Day	Yaar	3. Time of Death 20!35	
	/Medical Examiner	4a Facility Nama (If not institution, giva		1000		4b. City, Town, or Lo		4c. County of	of Death	0.0	
		Washington Advent				Takoma Pa			tgome	-	
	uneral irector		X 7. Aga	(In yrs. last birthday 89 Yrs.	Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day April 8	,1909	9. Birthpla Country Louis	ca (Stata or Foraign iana	
pue	B ss	Usual Rasidanca of Decedent 10a. Stata 10b. County		10c. City, Town or L	ocation				100	d. Inside City Limits	
Mary	28a-f show notflied at rector	Maryland Prince G	eorge's	Beltsvi	11e					1XX as 2□No	
death with the Maryland	r tems 23s or 28s-f s nive must be notified Funeral Director	10e. Street and Number 11203 Dorset Lane	9		10f. Zip Code 20	705	1	Og. Citizen of W United			
Te.	Evanior in Evanior in 1 by Funer	11. Marital Status 1 Nevar Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forcas? 1 ☐ Yas ♣️♣️No If Yas, Giva Yaar or Datas:	var in U,S. 13.	Was Decedent of H If Yas, specify Cub 1 ☐ Yes XXNo	dispanic Origin? (Sp an, Mexican, Puarto Specify:	ecify Yas or No- Rican, atc.)	Black	- Amarican k, Whita, at Whit	c.	
72	her than "natural", on The Hadical Evan Completed by	15. Decedent's Edu (Specify only highast grad Elamantary/Secondary (0-12) 12	cation a <i>completed</i>) College (1-4or 5+ 5+	(Give	odent's Usual Occup a kind of work done DO NOT use retire	petion during most of work d)	ing	16b. Kind of Bus United Of Agri	State	s Dept.	
laryland 2 should be flie	marked other than imatic event, trail. To Be Comp	17. Fathar's Nama (First, Middla, Last) John Thomas	Stokes			18. Mother's Name	(First, Middla, I Martin	_	ı) 11er		
Mary and 2 sho	27 ls mer traum	19a. tnformant's Name/Relationship (Ty Fadora L. Stokes			ing Address (Street	and Number or Run	el Routa Number	City or Town, S	Stete, Zip C	ode)	
Baltimore,	Department of Health and Mental Hygiene, Important: If item 27 is marked other than any Injury or other traumatic event, the Industry on the Injury or other traumatic event, the Industry once. To Be Comp	20e. Method of Disposition 1 ☐ Burial XX Cramation 3 ☐ F 4 ☐ Donation 5 ☐ Othar (Specify)	amoval from Stata		metory or other ple	matory 1/		20c. Location - C			
Balti Permit.		21. Signatura of Funeral Sarvice Licentum 22. Nama and Addrass of Facility Donald V. Borgwardt Funeral Home, F 4400 Powder Mill Rd. Beltsville, Ma									
		23a. Part1. Entar tha disaasa, or compl shock, or haart failura. List only or	cations thet caused the						11	Approximate ntarval Batween	
/M	esician edical aminer	Immediata Causa (Final disaasa or condition	A	NOXIA						Smin Death	
2	1	rasulting in daath)	Cê	va to (or as a conse	quence of):	are.		3	1	6 MIN 14 DA9S	
68760, ficate be execut	physician and s the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury	Dua to (or as a consequence of):								
Box 68760, ath certificate be ex	0 4	that initiated evants resulting in death) Last		ua to (or as a conse	quance of):						
. 0	the atterned for ysicia	Part II. Other significant conditions con	tributing to death but	not rasulting in the	underlying causa giv	ven in Part I.	23b. Dld to	obacco use con	tribute to t	the cause of death?	
S, P.O	2 65	Aorene	INS	ULFING	Enlay		10 Y	es 2 No	3 Probe	unknown	
Records,	should should	SUPRAVENT	RICUA	L TF	terge CA	COIA	24a. Was a perform	n autopsy med?	svail	e autopsy findings lable prior to pletion of cause aath?	
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Division or Attending after deeth.	raldi	Matural 5 ☐ Panding invastigation 3 ☐ Suicida 4 ☐ Homlcide 6 ☐ Could not be determined	5 □ Panding invastigation 6 □ Could not be							Routa Number,	
To the Hospital	Pletely filled edical Ce	29e. Certifier (Check only one)	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To the	To the	29b. Signature and titla of certifiar			29c. Licens	se number	2	9d. Date signed	(Month, D	ay, Year)	
)	5	* HWYLLIC	malalad as was of fi	th /ltom 22a) (Time	1) 3	53109		JANUAR	49,	1999	
		JDOWAN W JE	mpleted cause of dea	te ino	125207	hosperity	Dr. Sal	ver Sp	miny	Md 2 agos	
	State	31. Data filed (Month, Day, Year)	32. Registrar	s Signatura	lan	1					



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State of Maryland / Department of Health and Mental Hygiene

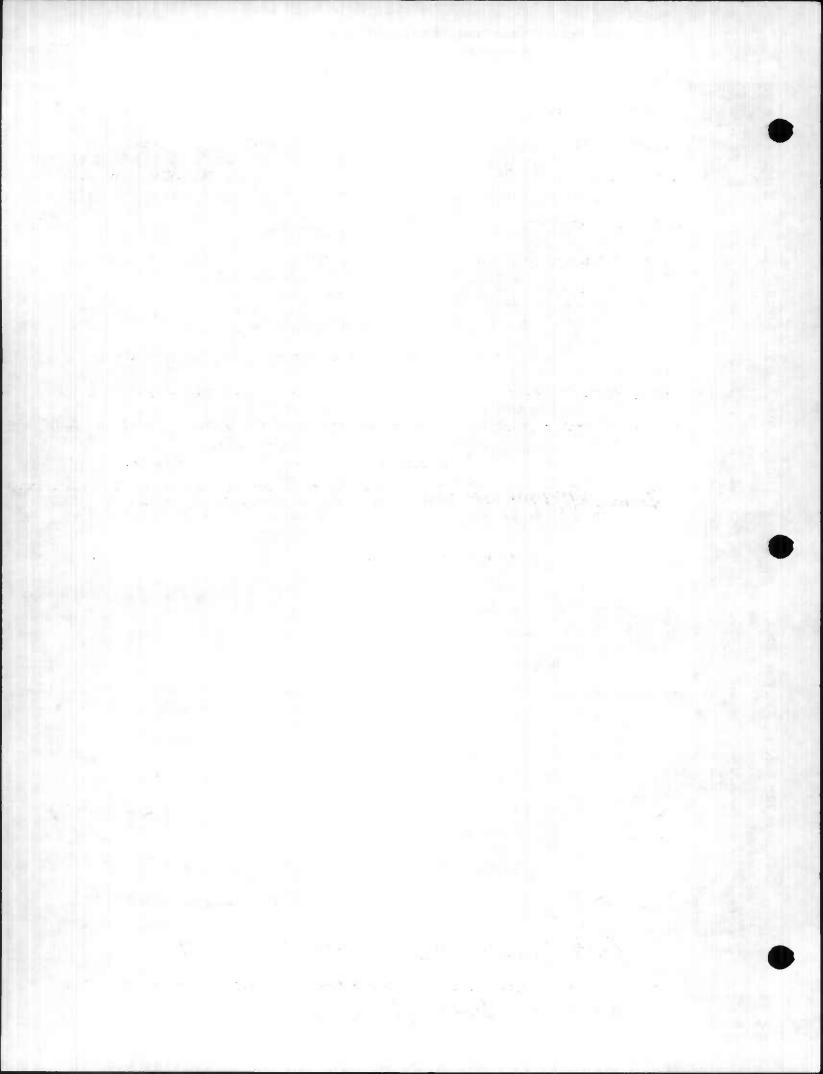
Certificate of Death 2. Data of Deeth 3. Tima of Death 1. Decedent's Nema (First, Middla, Last) **Physician** January 11, 1999 6:30AM Ruth A. Stokoe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner Rockville Montgomery Andrus House If Under 24 Hrs. If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 1□M 2X F Yrs 78 **Director** 068-20-8562 May 24, 1920 New York Usual Residence of Dacedani with the Maryland r 28a-f ahow inouffed at 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Maryland Montgomery Rockville 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda r than "natural", or items 23s or the Medical Examiner must be permit. Pagas 1 and 2 should be filed within 72 hours aftar death v Department of Haaith and Mental Hygiene. Important: if item 27 is merked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinar must onne. United States 20852 Funeral 10910 Old Georgetown Road 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) 4 Publishing Financial Secretary 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Helen Gertrude Allyn Harry Edgar Palmeter 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 20815 William C. Stokoe / husband 3519 Cummings Lane, Chevy Chase, Maryland 20b. Place of Disposition (Nama of cematary, crematory or other place) January 12, 1999 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 X Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funaral Service Licansaa 22. Nama and Addrass of Facility M00831 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. Darbara 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediata Ceuse (Final disaesa or condition resulting in deeth) /Medical Alzheimer's Disease 10 years Examiner Due to (or es a consequance of): Physician/Medical Examiner The lew requires that the death certificate be axecuted physician and s tha buriel-transit Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated avents rasulting in daath) Last Due to (or as a consequance of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): Se attending for usa as by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably W Unknown 2 signed b by 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed is cartificata has b 2 0 No 1 ☐ Yas 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was casa rafarred to medical Be 26. Place of Death (Check only ona) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Group Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 10 Yes 2□ No this 27. Manner of Deeth 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: Aftar 5 Pending invastigation daath. 1 Yas 2 No 2 Accidant eral Director: / 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Sulcida 6 Could not be datermined 28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) after 4 T Homicide fo the Hu.

within 24 hours

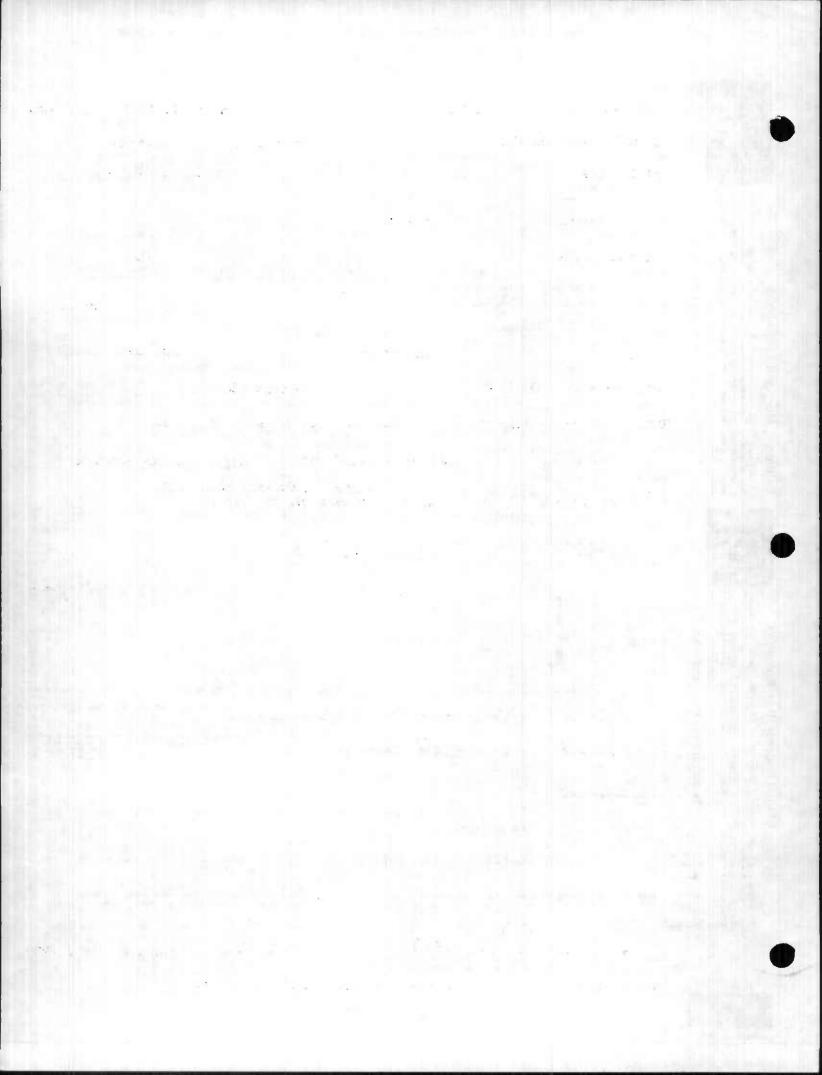
To the Funeral DP

mpletely filler Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) end menner as steted.

Medical Examinar: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. edical 29e. Certifier 29d. Data signed (Month, Day, Yaar) 29b. Signatura and title of 29c. Licansa number 30. Nema and addrass of person who completed causa of daath (Itam 23a) (Type, Print) 10801 Lockwood Drive, #200, Silver Spring, MD 20901 Alan Jay Diamond, M.D. 31. Data filed (Month, Day, Year) JAN 12 32. Registrar's Signatura State 1999 Docker Registrar



									Certi	ficate of	of E	eath			Reg. No.			
ľ		_	1. Decedent's Nam	e (First, Middl	e, Last)									2. Date of De	eath	V	3. Tim	ne of Death
	Physician		MARGA	RET JO	SEPHT	NE S	rempt e							Month Januar	v 7, 19	Year	225	Op.m.
	/Medical Examiner		4a Fecility Name (4b	. City, Tow		cation of Deet		y of Death		ораша
			SACRED	HEART	HOSP	ITAL					1	CUMBE	RLAN	D	ALLE	GANY		
ı	Funeral Director		5. Social Security N		6. Sex 1 ☐ M	2 X) F	7. Age (In y			If Under 1 Y Months De	eys	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, Di Jun 1	th (Year) 2, 1907	Cou	intry)	ate or Foreign
Н			Usual Residence o															
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	or 28	5	10e. Street and Nu	mber						10f. Zip Coo	de			16.00	10g. Citizen of	What Col	intry?	
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	r Herre 23s		11. Marital Status		12.	Was Dece Armed Fo	edent Ever in rces?	U,S.	13. Wa	s Decedent es, specify (of His Cuben	panic Orig , Mexican,	in? (Spe Puerto I	cify Yes or No Rican, etc.)	0- 14. Ra Bio	ce - Amer		n,
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p	be filed that Hyg d other event,		17. Father's Name	(First, Middle,	Last)						T	18. Mother	's Name	(First, Middle	, Maiden Sume	me)		
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ary	2 should and Men is marke	-	19a. Informant's N	ame/Relations	hip (Type,	Print)		19b.	. Mailing	Address (St	treet a				er, City or Town	, State, Z	ip Code)	
	Pages 1 end 2 near of Health a ent if them 27 is ury or other tre		Ruth A.	Wagon	erda	aught	er	Ro	oute	Box 1	1261	E: Ke	vser	, WV	26726			
Baltimore,		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Co												- City or	own, Stat	e		
9		1 X Burlal 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)											rland	, MD				
alt:		1	4 Donation 5 Dother (Specify) Sunset Memorial Park 01/11 Cumber1 21 Signature of Funeral Service Licensee Scarpelli Funeral Home, P.A.												LLOUIS	,		
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/	Physician: this certific ral director,		examiner?	No	Hosp	oital:	npatient 2	□ ER/Ou	tpatient	3□ DOA	Othe	r: 4 🗆 Nur	rsing Hor	ne 5 Res	idence 6 🗆 O	ther (Spec	cify)	
Jo L	After this funeral di		27. Manner of Deat			28a. Date	of Injury th, Day Year		Time of njury	28c.	Injury Work	at	1	28d. Describe	how injury occ	urred		
Ö	Attending or death. ector: After by the fune		1 Natural 2 Accident	5 Pendir investi	gation					М		res 2□N	No					
Division	tal or Attending P rs after death. al Director: After t ied in by the funers Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be	8e. Place	of Injury - A	home, fa	rm, stree	t, factory, of	ffice				(Street and Nur own, State)	nber or Ru	ral Route	Number,
	rs afformation of the control of the																	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	a la	29a. Certifier (Check only one)			On the ba									cause(s) and t , date and place			use(s)
	withir To the comp		29b. Signeture end	title of cortifie	1	7				29c. Li	icense	number			29d. Date sign	ed (Monti	n, Dey, Ye	var)
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	14.1	-	30. Name end addr	ress of person	who comp	leted caus	e de leath (I	tem 23a) ((Type, Pr	int)	-				Janua	- y	,	1777
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	Registrar	_	JA	NIII	999	1	red the	1	1.	GOOM	to	/						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** Elmer Theodore Steele January 1,1999 2218 pm · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Allegany Sacred Heart Hospital Cumberland 5. Social Security Number 7. Age (In vrs. jast birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Deys 1 M 2 F Months 181-01-4251 86 Director 02-Jun-12 Maryland Usual Residenca of Deceden with the Meryland 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛪 No Director Maryland Allegany Frostburg 10e. Street and Number 17505 Mount Savage Road, N.W. 10g. Citizen of What Country? 10f. Zip Coda 21532-U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 14. Raca - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 72 hours efter 1 Never Married 2 Married Specify White 1 Yes 2 No Specify: Maryland 21215-0020 à 3 Widowed 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Coal miner mining traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be 1 ent of Health end Mental I nt: If Item 27 Is merked of Herman Steele Mary E. Logsdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Valerie Butler Granddaughter 21532-17505 Mount Savage Road, N.W. Frostburg Maryland other 1 altimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Deta 1 Burial 2 □ Cremation 3 □ Removel from State permit. Page Department o Important: If any Injury or ò 4 ☐ Donation 5 ☐ Other (Specify) 05-Jan-99 Frostburg, Maryland Frostburg Memorial Park 21. Signature of Funeral Service Lie 22. Name end Address of Facility ohen Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final myo condin) Cont 2 days disease or condition rasulting in death) Examiner Dua to (or as a consaquenca of): Examiner pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): buriel-trar requires that the death certificete be exec physician es the buriel-Box 68760 Physician/Medical Due to (or es e consequence of): 80 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. ed by the deteched signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 SQinknown Line Records, þ 24b. Wara autopsy findings eveilable prior to completion of cause of daath? 24a. Was an autopsy Completed Obstructive filowners agens peen pege 2 1□ Yes 25 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attending Physician: director 25. Was case refarred to medical Be 26. Placa of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) Lo 1 Yes 2 No 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. fnjury et Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injun 1 Natural 5 Pending efter deeth. Director: Aft 1 Tes 2 No investigation 2 Accident 3 Suicide 6 Could not be datermined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 4 Homicida E To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Cartifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier D21244 my January 30. Name and address of person who completed cause of daath (Itam 23a) (Type, Print) 3 JESUS TAN, M.D. FROSTBURG PLAZA FROSTBURG MD. 21532 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JAN 04 1999 Beperson Registrar

Elmer Theodore Sleele

Allegany Cumberland Sacred Heart Hospital 181-01-4251 Maryland 02-Jun-12 Frostburg Allegany Maryland 17505 Mount Savage Road, N.W. U.S.A. 21532-While Coal miner COUNT Herman Steele Mary E. Logsdon Granddoughter 17505 Mount Savage Road, N.W. Frostburg Maryland 21532-Valerie Butler 05-Jan-99 Frostburg, Maryland **Erestburg Memorial Park**

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

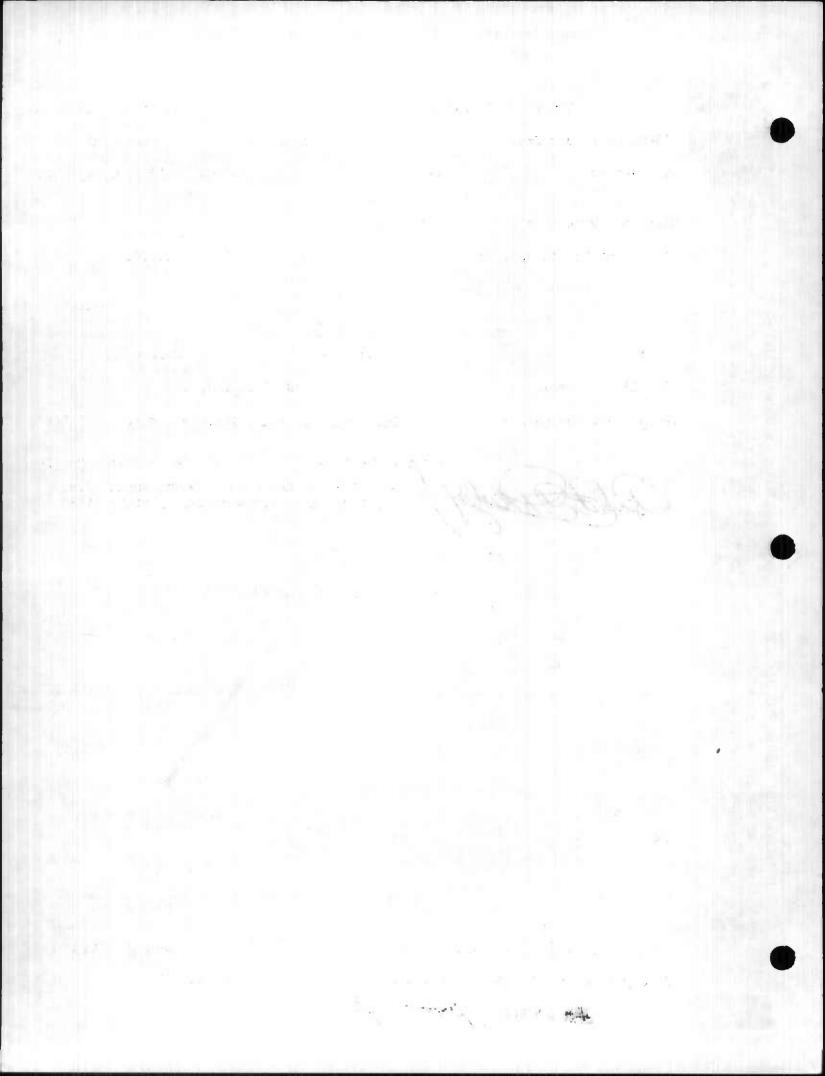
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey **Physician** YVONNE MARIE STOCKS 3, 1999 January 10:30 AM /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 13002 Mink Farm Road Thurmont Frederick If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 10 M 20 F Months Yrs. 217-56-0497 48 Director July 7, 1950 Pennsylvania Usuel Rasidence of Deceden permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or ferms 23s or 10 any injury or other traumatic event, the marked other process. 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Maryland Frederick Thurmont 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 144 Water Street Apt. #1B 21788 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (☑No If Yes, Give Yeer or Detes: 14. Rece - American Indian, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: P 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Neme (First, Middle, Malden Surname) 17. Fether's Neme (First, Middle, Last) Ray Alton Lescalleet Ida Bell Chipley 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda) 19e. Informent's Name/Reletionship (Type, Print) Tammy Frock (Daughter) 13002 Mink Farm Road, Thurmont, Maryland 21788 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Bretheen Cemetery 1/6/99 Rocky Ridge, Maryland 22. Neme end Address of Fecility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN ST. THURMONT, MARYLAND 21788 th. Do not enter the mode of dying, such as cerdiac or respiretory errest, Approximete Intervel Between Onset end Deeth shock or ba **Physician** Immediata Causa (Finet diseese or condition resulting in deeth) /Medical verian Examiner Dua to (or as a consequence of): Examiner ancreatic The law requires that the death certificate be executed Sequantielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Dua to (or es e consequence of) pue physician er s the buriel-t Box 68760 Physician/Medical Due to (or es e consequence of): 80 US. ò ed by the e 23b. Did tobecco use contribute to the cause of death? Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, g 24b. Were autopsy findings evellable prior to 24a. Wes en eutopsy performed? Completed peen completion of cause of death? certificate has 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was casa rafarred to madical exeminer? director, Be 26. Placa of Daeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 5 Panding Investigation Naturel n 24 hours efter deam.
he Funeral Director: Aft 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida Hospital edical 🕰 Certifying Physicien: To the best of my knowledge, deeth occurrad et tha time, date end plece, end due to tha ceuse(s) end manner es stated. 29a. Cartifier 2 Medicel Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one) To the F To the 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 48184 Dec. 5, 1999 30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print)
Elhamy Eskander, MD 501 West 7th Street, Frederick, Maryland 21701 Elhamy Eskander, MD 31. Deta filed (Month, Day, Year,

32. Registrer's Signeture

5 1999

State Registra



Physician /Medical

Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the daath certificata be asscuted within £4 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneral director, page 2 should be detached for use as the buriar-transit

Physician /Medical

Examiner

		State	of Maryla				Health an <i>Death</i>	d M	ental Hygi	ene	9 0	1670
1. Decedent's Nam	e (First, Middle	a, Last)							2. Date of Death			3. Tima of Death
	Alice A	Alma Sanbov	wers						Tanuary Tanuary	Day	199 g	1725
la. Facility Nama (Washin		n, giva straat and i					4b. City, Town		cation of Death	4c. Count	of Death	1
5. Social Security N 213-24-8018		6. Sex 1 □ M 2 💢 F	7. Age (In yi	s. last birthd Yrs	Mont	hs Days	-	Hrs. Min.	8. Date of Birth (Month, Day, 1	Year) 1930	9. Birthp	
Usual Residence o									-T 3			
10a. State	10b. County		100.0	City, Town or							1	Od. Inside City Limits
Mi.	Washir	ngton		Sharps	burg							1 ☐ Yas 2 ☐ XNo
0e. Street and Nu					10f.	Zip Code			10	g. Citizen of		itry?
4901	General	Branch Ct.				2	21782			U.S.A		
Marital Status Never Marr		Armed	ecedent Ever in Forces? s 2 % No Give	U,S. 1	If Yas, s	specify Cut	Hispanic Origin ban, Mexican, P	? (Spe uerto F	cify Yas or No- Rican, atc.)		ck, White,	etc.
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7. Father's Name	_	-							(First, Middle, Ma	alden Sumer	na)	
		Snoots					Maria					
9a. Informant's N Malea R. S		hlp (Type, Print) S (Daughter	:)				anch Ct.,		rpsburg, M	City or Town		Coda)
0a. Method of Dis 1 ☐ Burial 2 4 ☐ Donation	Cremation	3 □Ramovai from Decify)	m State	Place of Di camatary, o mithsbu	rematory	or other pla		1		oc. Location		
21. Signature of Fu	cal	Honsey Con	AF.		Donal	d B. 7	lhompson I St., Mick			21769		
23a. Part . Enter t shock, or hea	he disease, or rt feilure. List	complications to	daused the de	ath. Do not	enter the n	node of dy	ring, such as car	rdiac o	r respiratory arres	st,		Approximata Interval Between
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resulting in daath)		- a	oudio -	(das a con	sequence	d: m	failu	hins	infar	ction		3 days
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art II. Other signif							iven in Part I.		23b. Dld tob	acco use co	entribute to	the cause of death?
ende	otage r	enal d	ù56.52	bn					1 🗆 Yes	2 No	3 Prot	pably 4□Unknow
Chron	nic.	enal d periton	eal e	haly	4,73.				24a. Was an performa		av	ere autopsy findings allabla prior to mpletion of cause death?
)					1 □ Yes	2 No	10	Yes 2□ No
5. Was case refer	red to medical		/				26. Plece of	Death	(Check only ona,)		
examinar?	No	Hospitei:	Inpatient 2	☐ ER/Outpa	tient 3	DOA O	ther		ne 5 Residen		ner (Specifi	y)
7. Manper of Deat 1 Natural 2 Accident	5 Pendin	28a. Dat (Mc	a of Injury onth, Day Year)	28b. Time Injur	e of	28c. Inju		1	8d. Describe how			
3 ☐ Sulcide	6 ☐ Could r	ot be 28e. Pla	ca of Injury - At Iding, etc. (Spec	billion from	etroot foo	tony office		2	8f. Location (Stra	at and Num	ber or Rura	I Routa Number

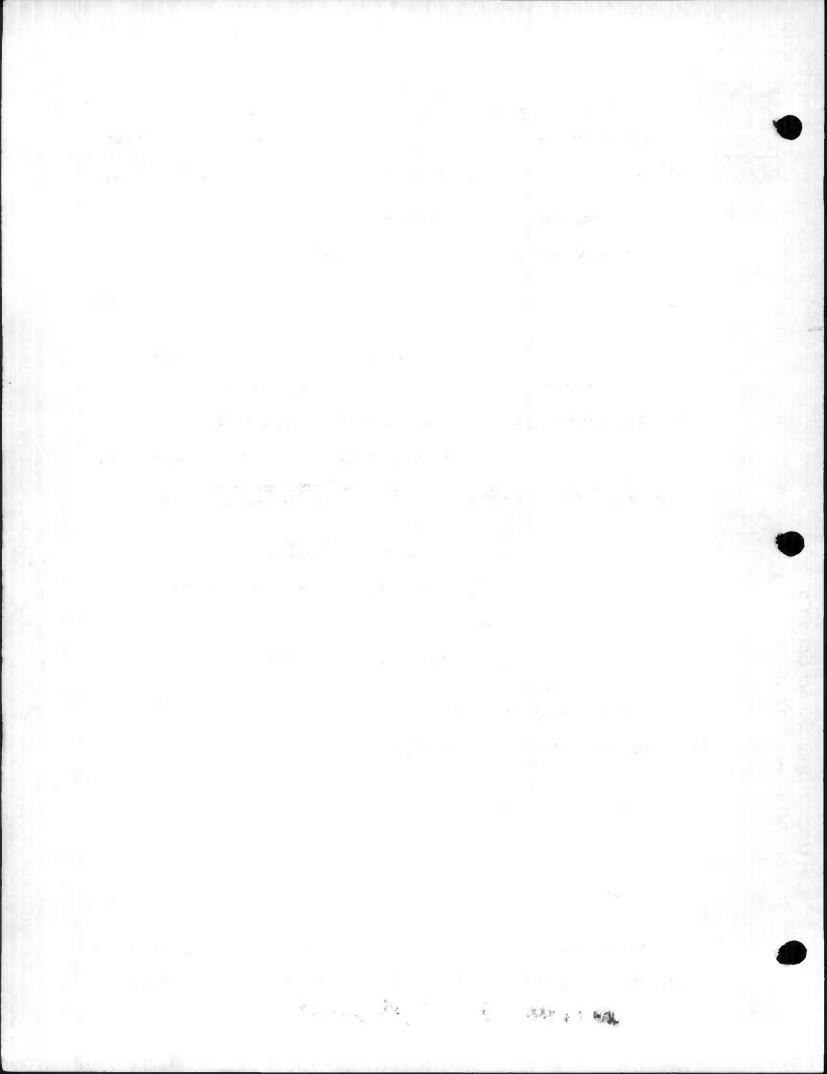
State Registrar

29b. Signature and title of certifian YANDWA



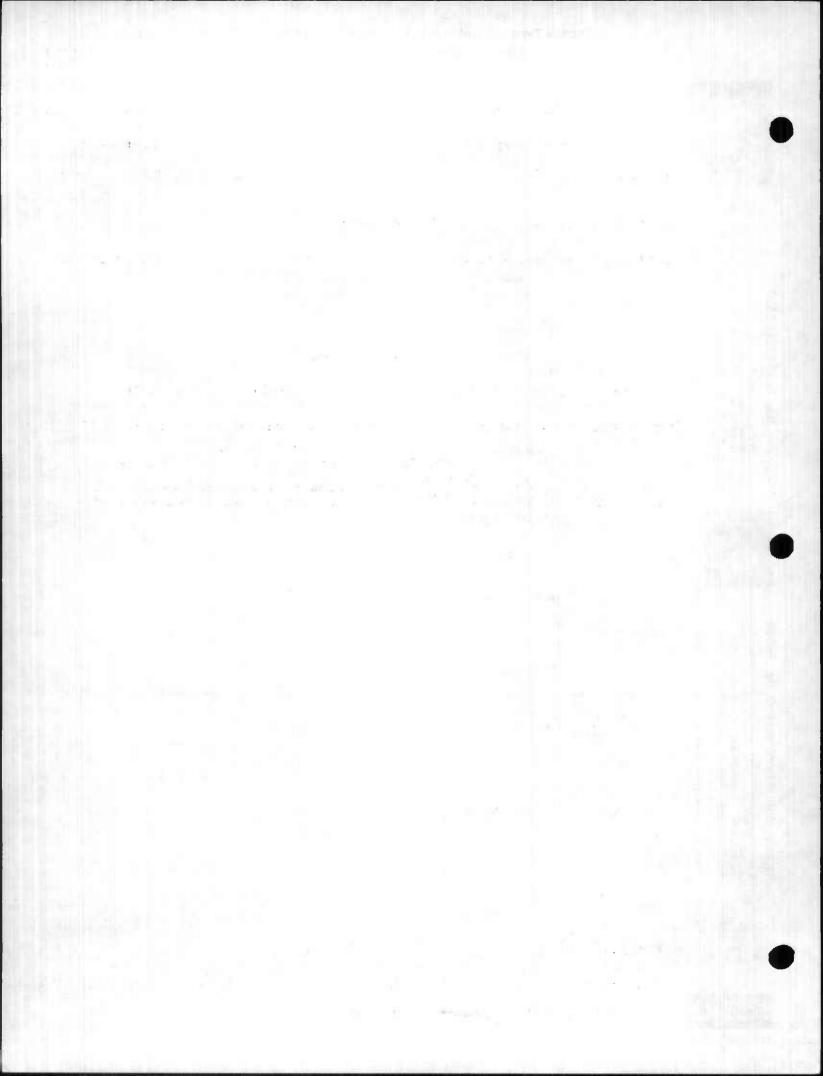
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Maryland



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			C	ertificat	e of L	Death		g. No.	U	1011				
Physician	1. Decedent's Neme (First, Middle, La	st)					2. Date of Death Month	Day	Year	3. Time of Death				
/Medical Examiner	Lionel A. Tothi 4a Facility Name (If not institution, giv				4	b. City, Town, or L	January	9, 19 4c. County	-	10:28 AM				
Examiner	Montgomery Genera	1 Woonital				Olney		Mon	tgome	2037				
Funeral	5. Social Security Number 6. S	ex 7. Aga	(In yrs. last birthde	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Data of Birth (Month, Day,	Year)		ace (State or Foreign				
Director	214-03-8165 Usual Residence of Decedent	9	3 Yrs				October 19	9, 1905	Eng	land				
show	10e, State 10b. County		10c. City, Town or	Location					10	d. Inside City Limits				
be notified at Director	Maryland Montgom	nery	Silve	r Spri						1 ☐ Yes 2 ŽÎNo				
2 0	10e. Street and Number			10f. Zip		006	10	g. Citizen of V						
Funeral	3347 Hewitt Aver	12. Was Decedent E		3. Was Deced		906 spanic Origin? (Si n, Mexican, Puert	pecify Yes or No-	14. Rao	ed St a - America	n Indian,				
by Fun	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forcas? 1 2 Yes 2 No If Yes, Give Year or Dates:	1925-	If Yes, spec			o Rican, etc.)	Specify						
ed the	15. Decedent's Ed	ducation		cedent's Usua	al Occupa	ation furing most of wor	1	6b. Kind of Bu	Whi siness/Indu					
rt, fre Medical I	(Spacify only highast gra Elementary/Secondary (0-12)	da completed) College (1-4or 5-	life	ive kind of wo a. DO NOT us	rk done d se retired	furing most of wor.)	king							
f. O	4 17. Father's Name (First, Middle, Last)		Н	ead Ho	usem		ne (First, Middle, M	Hote						
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	19a. Informant's Name/Relationship (ailing Address	(Street		ral Route Number,			Code)				
other traumatic ev	Irma G. Miller /	daughter	2 C1	cooked	Isla	and Circl	e, Murre							
5	20a. Method of Disposition 1 X Burial 2 Cremation 3	20c. Location - City or Town, Stata												
Annia .	4 Donation 5 Other (Specify) St. John's Cemetery Silver Spr. 21. Signature of Funeral Service Licenses A MOOR 31 22. Name and Address of Facility													
any injury o														
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Comp							1 ☐ Ye	s 210 No	10	Yes 2□ No				
director, peg	25. Was case referred to medical examiner?						ith (Check only one	э)						
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fune	1 Naturel 5 Pending investigation 3 Suicide 6 Could not be a determined determined 28a. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Routs Injury - At home, farm, stree									Routa Number,				
Cert	4 Homicide	building, etc.	(Specify)				City or Town	, State)						
completely tilled in by the Medical Certifical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of niner: On the basis of and manner stat	examination and/o	eath occurred r Investigetion	et the tin	ne, date and place pinion, deeth occu	, and due to the ca rred at the time, da	use(s) and mi ite and place,	anner as sta and due to	ated. the cause(s)				
we we	29b. Signatura and title of cartiller	0	~	290	c. Licens	e number	25	d. Date signe	d (Month, E	Day, Year)				
	Dronk.	pula	wo	K	153	459	7	proge	9	,1999				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)													
+1	30. Name and address of person wha	La Jono		pe, Print)	Pai	nce Ohi	10 Da	· Oln	SUM	4 20832				



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3 Time of the th 1 Decedent's Name (First Middle Last) JANUARY PRY 1998 --2:09 M BETTY JEAN TRADER 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND If Under 24 Hrs. 8 ALLEGANY if Under 1 Year 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 M XDF Months Deys Hours Min Yrs. 365-05-3333 Sep 13, 1917 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Y☐ Yes 2 No Prospect Hts Cook 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 N. Wolf Road 60170 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X☐ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes X☐ No Specify: **¾**□ Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Triple A Auto Map Writer 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) nfn nmn 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Dawn Zobel--granddaughter 11909 McMullen Highway; Cumberland, MD 21502 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burlal 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memory Gardens Arlington Hts, IL 01/14 21. Signature of Funerel Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland, MD 21502 Do not enter the mode of dying, such as cerdiac or respiretory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Coronary artery disease unknown Due to (or es a consequence of): Chronic obstructive pulmonary disease unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior fo completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

Be

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Certification:

Physician

/Medical

Examiner

10a. State

TI

Directo

Funeral

by

Completed

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Emminerments in portional and once.

physician and the burial-transit USB as ! attending p ed by the a signed by t been sig certificata has b

The law requires that the death certificate be assocuted Physician: this funaral After or Attending aftar death. Diractor: / 24 hours after Funeral Dira letely filled in b To the Hospital o within 24 hours at To the Funeral D

TRADER 365-05-3333 Division of Vital Records, P.O. Box 68760,

edical 8 State

Registrar

31. Dete filed (Month, Dey, Year)

29b. Signature and title of cartifier

25. Wes case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Neturel 2 Accident

3 ☐ Suicide

29a. Certifie

4 Homicide

(Check only one)

Hospital:

5 Pending investigation

6 Could not be determined

W.D

1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of Injury

29c. License number D 40693

28c. Injury at Work?

1 Tyes 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated.

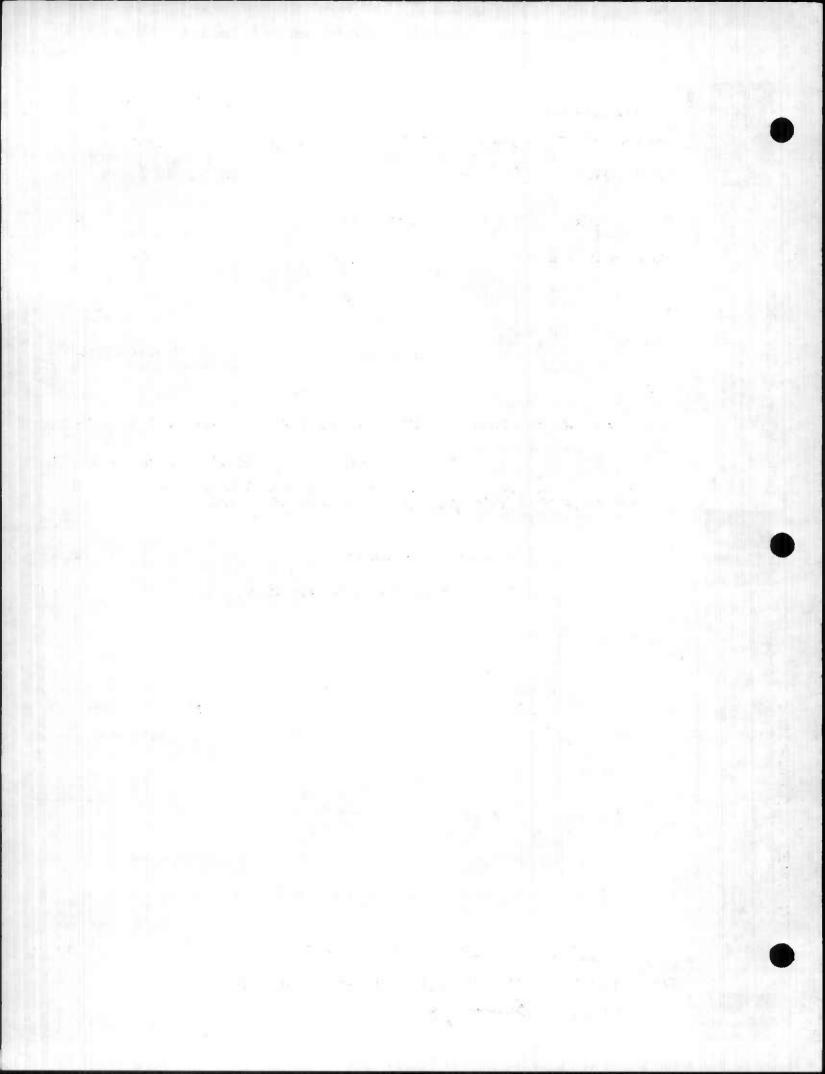
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the fime, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

SAMIR ELIAN M.D., 921 SETON DRIVE, CUMBERLAND, MD

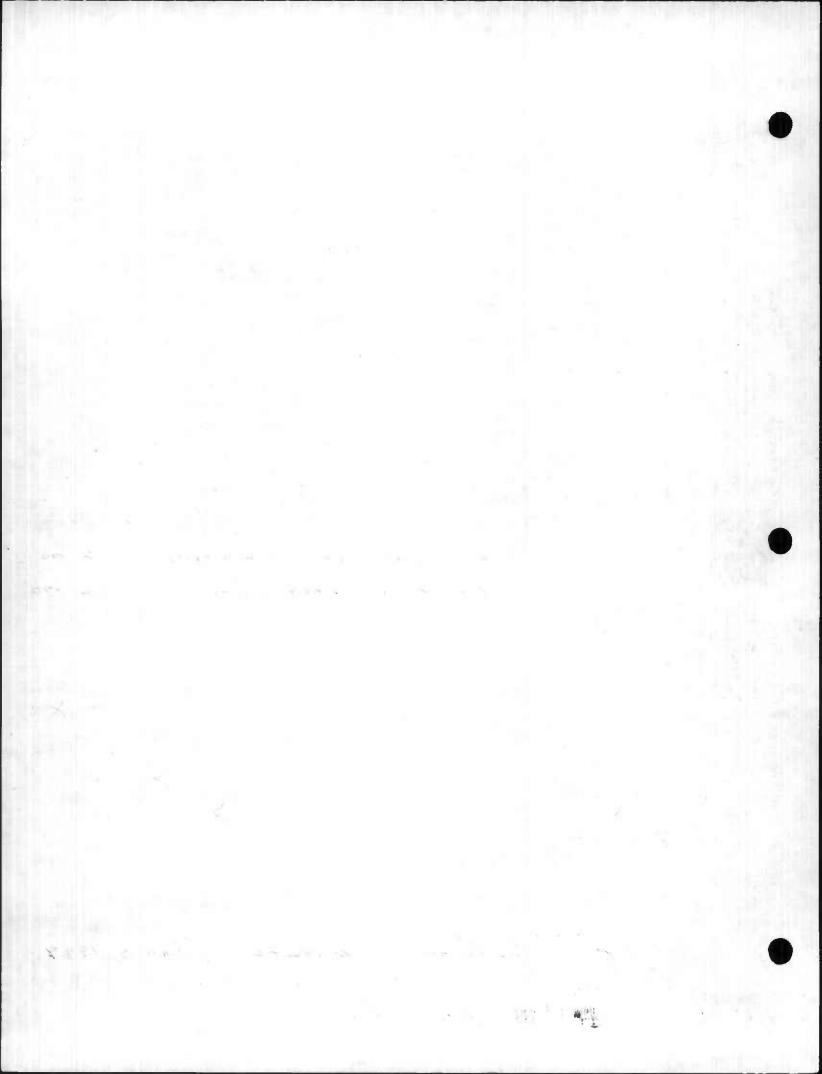
32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene 9 9 0 1 6 7 3

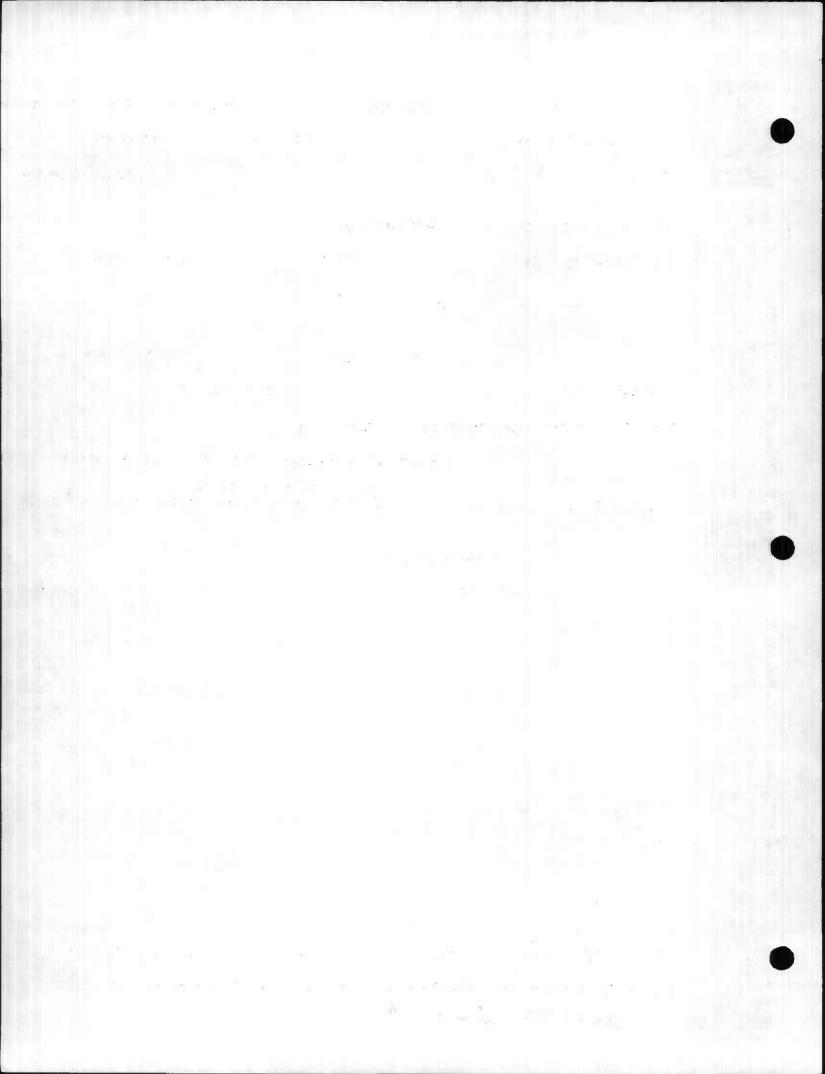
								Certi	ificate	e of	Death		Я	eg. No.	U	10	10
-			1. Decedent's Name (First, Mid	de, Las	st)								2. Date of Dear				e of Death
	Physicia	-	Leroy Terry										Jan.	1,199	Year	1:1	5 AM
201	/Medica	_	4a Facility Name (If not Instituti	on aive	e street end no	umher)					4b. City. To	wn. or L	ocation of Death	4c. County		1	
A	Examine	r				01110017											
			200 Maple Av	-		1			K I la dan	4 1/2 22	Fred			Fred			
	Funeral		5. Social Security Number	6. S	ex Mom 2□F		n yrs. last birt	1	If Under Months		If Under Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	ilace (Sta itry)	ite or Foreign
ш	Director		163-30-9719		(2) M 2D 7	61		Yrs.					Feb.	19,193	7 Vi	rgi	nia
7	2	-	Usual Residence of Decedent			Tar	0 0 T	1									
	how a		MD. 10b. Countries Fred		ale		Oc. City, Towr								,		e City Limits
		9	mb. Fred	eri	CK		Frede	LIC	K							1X1	res 2 No
4	82	<u>ē</u>	10e. Street and Number						10f. Zip	Code			1	Og. Citizen of V	Vhat Cour	itry?	
	38		200 Maple A	ven	iue				2	170	1			U.S.A	1.		
	death with the Maryland irre 23e or 28e-f show c must be notified at	Funeral Director	11. Marital Status		12. Was Dec	cedent Eve	er in U,S.	13. Wa	as Deced	ent of h	lispanic Ori	igin? (Sp	ecify Yes or No-		e - Americ		٦,
	2 2	2	1 ☐ Never Married 2 🖾 Ma	rried	Armed F	orces?			0.0000			n, Puerto	Rican, etc.)		k, White,		
320		2	3 □ Widowed 4 □ Divorce		If Yes, G	ive		10	Yes 2	2 DONo	Specify:			Specify	Blac	ck	
ŏ j	natural, or its		15. Decede	ot's Ed			160	Deceder	nt's Usua	Occur	nation			16b. Kind of Bu	isiness/Inc	dustry	
21215-0020	a d	Completed	(Specify only high	est gra	de completed,)	100.	(Give kir	nd of wor	k done	during mos	t of work	ing				
12	then.	티	Elementary/Secondary (0-12)		College	(1-4or 5+)								Alumi	num	Pla	nt
7	Hygie fther mrt, 12	ဒီ -	9th 17. Father's Name (First, Middle	(C	ons	truc	CLL		ada Mara	e (First, Middle, I	Maidan Cumam	101		
5	d dog	9	Daniel Terry												0)		
<u> </u>	nd Mental Hygie marked other t umatic avant, to	9	Junior refr								ATI	gre	Thomps	son			
ā			19a. Informant's Name/Relation				19b.	Mailing	Address	(Street	and Numb	er or Rur	al Route Number	r, City or Town,	State, Zip	Code)	
	and 127		Rosetta Terr	У	(wife)						Ave.,	Fre	derick	Md. 2	1701		
o .	S T He		20a. Method of Disposition				20b. Place of	Disposit	tion (Nan	ne of ther nie	ce)		Date	20c. Location -	City or To	wn, State	0
Ĕ	nent of int: If Ith		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (n State						+.	1-8-99	Owings	Mil	110	БМ
		-	21. Signature of Funeral Service					00.4	lama an	al A alaba		m					
Ba	Departi Importu any inje		21. Signature of Funeral Service Licensee 22. Name and Address of Gary L. Rollins Funeral Home 110 West South Structure Home														
			23a. Payl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Inte														.2170
-			23a. Pay(1. Enter the disease, shock, or heart failure. Li	or comp	plications that one cause on	each line.	e death. Do n	not enter	the mod	e of dyi	ng, such as	cardiac	or respiratory arr	est,			
P	hysician	snock, or heart failure. List only one cause on each line.														Onset a	and Death
	/Medical	Immediate Cause (Final disease or condition resulting in death) a. Con re[ated = cach = 8:9]													1	2	ma
E	Examiner		resulting in death)		a	Du	e to (or as a c	-Onsonus	ance off.	7 -	-		,04 ()	()	1		
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1	ansit	Ē			b		e to (or as a c			- V	ee)		C7		1	6	~10
	al-tra	X	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			Du	e to for as a c	Misodne	once on.						1		
68760,	definition of the property of the principle of the princi	edical Examiner	Cause (Disease or injury that initiated events	~	c										- !		
0	the		resulting in death) Last			Due	e to (or as a c	onseque	ence of):						1		
X	5 6	Σ			d										t t		
00															1	E C.	
. 3	ed by the atterdetached for u	Physician	Part II. Other significant condit	lons co	ontributing to d	death but n	ot resulting in	the und	erlying c	ause gi	ven in Part	l.	23b. Did to	obacco use co	ntribute to	o the cau	se of death?
0	by t	2											1 D Y	es 2 No	3 Pro	bably	4) Unknown
	been signed be should be deta	2		-													
0	n sig	8											24a. Was a			ere autop	osy findings
0	» II (i)	Completed											perfor	meu ?	co		of cause
9	has b	립															
T F	at a d												1 D Y	es 2 No	11.	Yes	2∐ No
	certificata	9	25. Was case referred to medic examiner?	al								e of Deal	th (Check only or	10)			
	this certific	0	1 Yes 2 No		Hospital: 1	Inpatient	2□ER/Ov	tpatient	3□ DC	A	her: 4 N	ursing Ho	ome 5 Resid	ence 8 DOth	er (Specif	y)	
ם פ	a de la		27. Manner of Death		28a. Date	of Injury orth, Day Ye	28b. T	Time of	2	8c. Inju Wo	ry at		28d. Describe h	ow injury occur	red		
VISION	e for	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28b. Time of Injury at Work? 1 Yes 2 No 28b. Place of Injury - At home, farm, street, factory, office 28b. Place of Injury - At home, farm, street, factory, office 28b. Time of Injury at Work? 28c. Injury at Work? 28b. Time of Injury at Work? 28c. Injury at Work? 28b. Time of Injury at Work? 28c. Injury at Work? 28b. Time of Injury at Work?															
SI/	of the	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office										28f. Location (S	treet and Numb	er or Run	al Route i	Number,	
Division or Vital Records,	after death. Director: After to in by the funeral	4 Homicide building, etc. (Specify)										ii, Sialej					
100	3230		29a. Certifier **Certify	na Ph	vsician: To the	e best of m	v knowledoe	, death o	occurred	at the ti	me, date ar	nd place	end due to the c	ause(s) and ma	anner as s	tated	
3	Fun Fun	edical	(Check only 2 Medics	Exam	niner: On the b	basis of ex	amination and	d/or inve	stigation,	in my	opinion, des	th occur	red et the time, o	late and place,	and due to	o the cau	se(s)
4	m pla		29b. Signature and title of certif	ar le	Dill Drip	stated			200	Licen	se number			29d. Date signe	d (Month	Dav. Ye	ar)
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			THE STATE OF THE S		-	Ke	40			0	146	20		1011	5	199	9
			30. Name and address of perso	who o	completed cau	use of death		-	rint)	7	h	1	rederic	6 04	0 -		
			P. Gregory	K	AUSC	y r	ND.	501	W	. 1	. 24	TI	reduric	K IVC	10	1110) (
	State	,	31. Date filed (Month, Dey, Year)		Registrars			6		1						
	Registra		JAN	0 6	1999	1	men	1	J.	1	DOUB	/					



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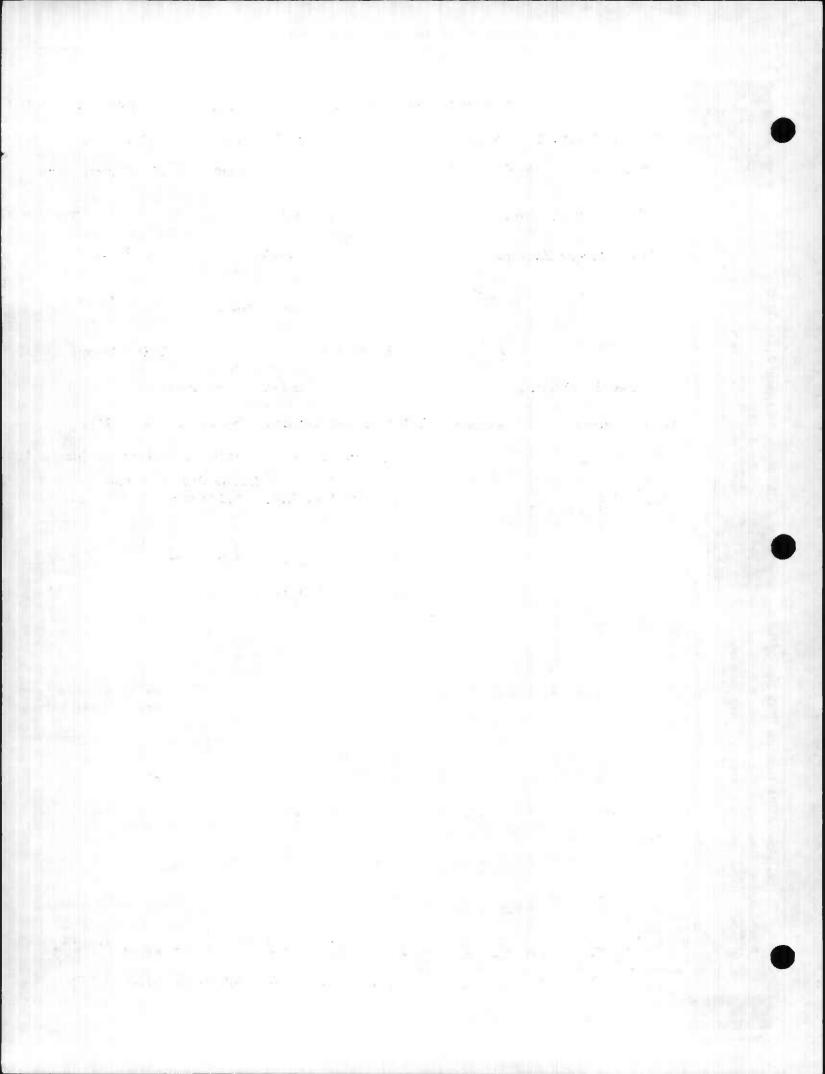
Physician	1. Decedent's Ne	me (First, Middle, La	st)			5507	1.7		2. Dete d		Day	Veer	3. Time	of Death	
/Medical		Herman			Willi	iams			Jani	ary	Day 11, 1	999	11:	10PM	
Examiner	4e Facility Name	(If not institution, giv	e street end number,					4b. City, Town, o		eeth	4c. County	of Deeth			
	9219 S	tewartown	Road					Gaither	sburg		Montg	omery	7		
uneral rector	5. Sociel Security 577-24-	3026	Sex 7. Ag	ge (In yrs. 75	lest birthday Yrs.	y) If Unde Months	Deys	If Under 24 H Hours M		f Birth Dey, Ye 1, 1	923			te or Forei	
ehow ed at	Usuel Residence 10a. State	10b. County		10c. City	y, Town or l	Location				-		11		City Limi	
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or 28a-f o Director	10e. Street end N	lumber					p Code			10g.	Citizen of V	Vhat Coun	try?		
	9219 St	ewartown	Road			20	0879			Uni	ited S	State	S		
r Homs 23a	11. Merital Status		12. Was Decedent Armed Forces	Ever in U,	S. 13			lispenic Origin? en, Mexicen, Pu	(Specify Yes o		14. Rec	a - Americ	an Indien		
° 11 >		arried 2 Married	1 X Yes 2 ☐ If Yes, Give Yeer or Detes:	No	II			Specity:	eno Hican, etc	,	Specify	k, White, o			
natural.		15. Decedent's E		7777		edent's Usu	Jel Occup	ation		16b	. Kind of Bu				
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vent.	17. Fether's Neme	e (First, Middle, Last)		ria1.	I_Cal	LIEL	18. Mother's N	leme (First, Mi	ddle, Meid	den Sumem	ne)			
c ever	Roland	Williams						Restri	ice Ham	mond					
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ther the	VICTOR12		West (da			Sam position (Ne	e as	10	Dete	200	Location - City or Town, Stete				
는 O	1 XBurial 2 □ Cremation 3 □ Removel from State cemetery, cremetory or other place)														
Jury												Mary	land		
Important: If item 27 is any injury or other tra once.	21. Signature of I	Funeral Service Lice	nsee		F	22. Name a	nd Addre	ss of Fecility	ices.	P.A.					
F # 9	22. Name and Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20 23e. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interviel Believe interval Believe.														
	23e. Part1. Enter	r the diseese, or com	plications thet cause	d the deeth									Approxir Intervel I	nete	
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miner	diseese or condit resulting in deeth	n)	e. Metasta			equence of	۸.				-		6 months		
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i physician and is the burial-transit edical Examiner			b. Colon (equence of	١.					1	o IIIO	itns	
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Ph the	resulting in death) Lest		Due to (or	es e conse	equenca or)									
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Physician /Medical		Blanquita	M.	Wende			Jan.	10 1	999	7:32	P.M.
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	e. <u>Co</u>	1	5 re		heart	fai/u	v	-	3 mo	5.
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To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:		ysictan: To the best of my kno liner: On the basis of exemine end menner stated.									(s)
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State Registrar	31. Date filed (Month, Day, Year)	32. Registrer's Sign	ature	9 1	Day W	11					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Harry Harold Weber JANUARY 05,1999 06:00A 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) Allegany Sacred Heart Hospital Cumberland If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 34 Birthplece (State or Foreign Country) PA 5. Sociel Security Number 7. Age (In yrs. last birthday) X M 2 F Months Deys Hours Yrs. 64 177-26-9236 Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 12302 Bowling Street 21502 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Ž☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Maritel Stetus 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X No Specify: Specify 3 Widowed & Divorced white 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry Elementery/Secondary (0-12) College (1-4or 5+) Weber's Dance Emporium Owner/Operator 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Harry Harold Weber Marie (NMN) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 12302 Bowling Street Cumberland MD 21502 Vincent Snyder-friend 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 N Buriel 2 □ Cremetion 3 □ Removel from State St. Mary's Cemetery 01/08 Cumberland MD 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, P.A. Cumberland MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Ceuse (Final disease or condition resulting in deeth) Kesperer Kes IWR Sequentielly list conditions, if eny, leeding to immediate cause. Enler Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Wes an eutopsy performed? 1 Yes 2 17 No 1 ☐ Yas 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how Injury occurred 28b Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner es stated. 2 Medical Examinar: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29e. Certifier (Check only one)

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State Registrar

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29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Seton M.D 902

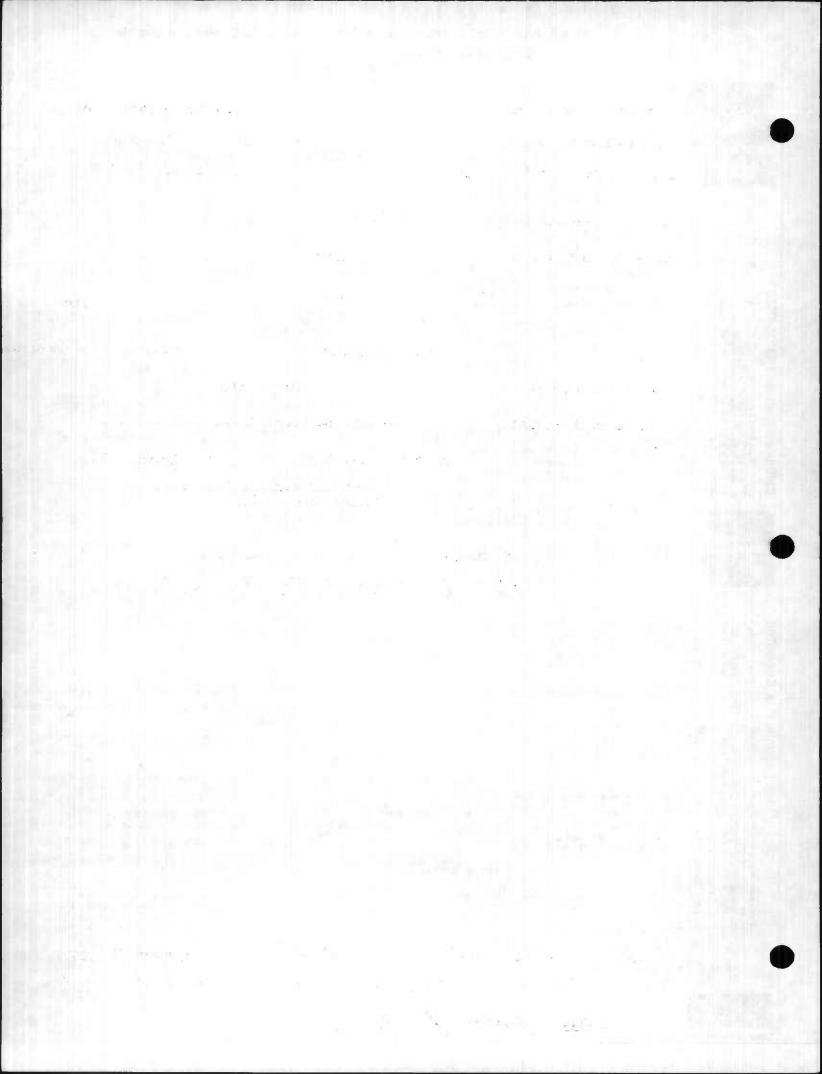
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elandia 31. Dete filed (Month, Dey, Year)

29b. Signeture end title of certifier

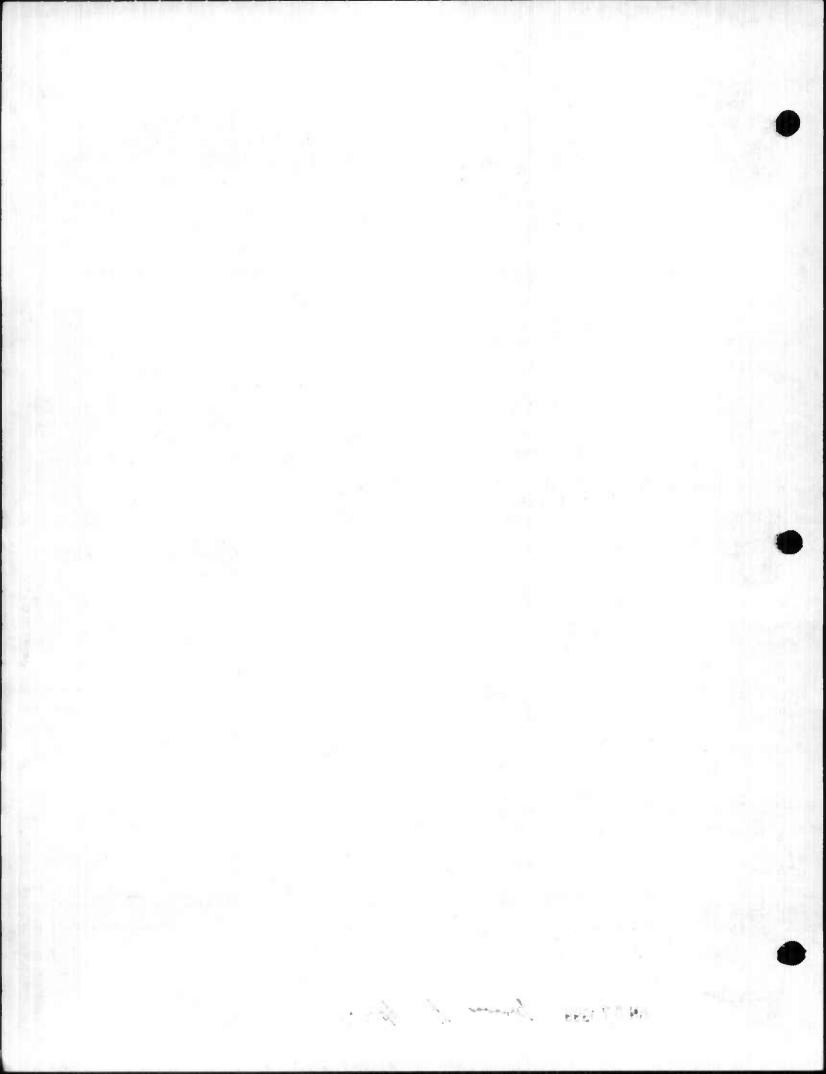
32. Registrer's Signeture

IAN 0 8 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q

-	-	Decedent's Name (First,	Middle, La	st)		Cei	tificate of	Death	2. Dete of De	Reg. No.		3. Time of Deeth
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Examin	er	1008 FREDER			iiii.Deij		No.	CUMBER			EGANY	
Funeral Director		5. Social Security Number 215-20-5619	6. S	ex □ M 2□F	7. Age (In	yrs. lest birthday) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min.	8. Dete of Bir (Month, De APRIL 8			elece (Stete or Foreign etry)
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28a-f show	_	10e. Stete 10b. Co	unty		10c	City, Town or Lo	cation				1	0d. Inside City Limits
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23a or 28a-f should be notified at	Dire	10e. Street end Number					10f. Zlp Code			10g. Citizen of	Whet Cour	ntry?
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iena. r than "natural", or flerne the Medical Examiner m	by Funeral Director	11. Marital Status 1 □ Never Merried 2 ☒ 3 □ Widowed 4 □ Divi		12. Was Dec Armed Fo 1 Yes If Yes, Gi Yeer or D	orces? 2 XNo ve	- 11	Vas Decedent of H f Yes, specify Cub ☐ Yes 2 XNo	dispenic Origin? (S en, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Specif	ce - Americ ck, White, y: WH	
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arke atic	10	DALTON LEPLE	Y					CORA Mc	COY			
is m	П	19a. Informent's Neme/Rele	tionship (7	ype, Print)		19b. Mailin	g Address (Street	end Number or Ru	rel Route Numb	er, City or Town	Stete, Zip	Code)
Itam 27 is marke other traumatic	Н	WALTER T. WE	ED					K STREET	CUMBERL	AND MAR	YLAND	21502
Important: If item 27 any Injury or other tr		20e. Method of Disposition 1 □ Burial 2 □ Creme	ion 3 🗆	Removei from		 b. Place of Dispose cametery, crem 	sition (Nem <i>e of</i> netory or other ple	ce)	Dete	20c. Location	- City or To	wn, Stete
ury o		4 □ Donation 5 □ Oth			CI	JMBERLANI	O CREMATO	ORY JAN 7	1999	CUMBERL.	AND M	ARYLAND
y Injury	Suc	21. Signature of Funeral Service Ligardee 22. Name and Address of Facility										
5 8		MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND shock, or heart failure. List only one ceuse on each line.										
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year Anuary S 0139 Miriam Catherine Wolf 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 2□ F 217-48-9679 71 December 29,1927 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Frederick Smithsburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 12826 Loy Wolfe Road 21783 USA 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Daniel Ralph Kepler Ruth Esther Schildknecht 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Cyrus E. Wolf/Spouse 12826 Loy Wolfe Road, Smithsburg, Maryland 21783 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) \$t. Mark's Lutheran Cemt. 1-8-99 Wolfsville, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 Bette plications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, one cause on each line. Approximata Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) Heart Frilure years Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Y88 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending 1 TYes 2 □ No investigation 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Examiner 80 080 signed by the atte Mistam Dage 2 Vital certificate or Attending Physician: Division of After this No K 24 hours after death. Hospital within 2 \$

Physician

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Funeral

Director

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Pages 1 and 2 should be III ment of Health and Mental H ant: If them 27 is marked oth jury or other traumatic even

Physician

/Medical

Baltimore, Maryland 21215-0020

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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Death Neturel 2 Accident 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one)

nu-

29b. Signature and title of certifier

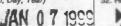
29c. License number () 2145

29d. Date signed (Month, Dey, Year)

Neme and address of person who completed cause of death (Item 23a) (Type, Print)

ABOUL WATERD MO- 12821- OAK HILL AVE. HAGERSTOWN. MO21742 32. Registrer's Signature 31. Dete filed (Month, Day, Year)

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death R sician TEBORY 202pm Medical 48 Facility Nama (If not institution, giva street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BAHIMOGE CITY Magi 5 HIMOGE If Under 1 Year If Under 24 Hrs. 8. Data of Birth SEPT 20 12951 6. Sex 1 M 2 □ F 9. Birthplaca (Stata or Foreign WESTY) VIRGINIA 5. Social Security Number 7. Aga (In yrs. last birthday) Days Hours 47 Yrs. 213-58-4805 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6984 MILBROOK PARK DRIVE 21215 U.S.A. Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, etc. Never Marriad 2 Married 1 Tes 2 No Specify.WHITE 1 Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Yaer or Datas Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) Collega (1-4or 5+) CABLE TECHNICIAN 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Be APPLE DAVID INEZ **ENOS** 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3903 CARTHAGE ROAD RANDALLSTOWN MD. 21133 MARLENE FELDMAN/ SISTER 20b. Placa of Disposition (Nema of Data 20c. Location - City or Town, Stala 20a. Mathod of Disposition BALTIMORE HEBREW CEMETERY 1/22/99 REISTERSTOWN MD 1 XBurial 2 □ Cramation 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 21, Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarvat Between Onset and Death fmmediata Causa (Finet disaasa or condition rasulting in deeth) Examiner Sequentially list conditions, if any, laading to immadiate causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in daath) Last Due to (or as e conse Physician/Medical Dua to (or as a consequanca of): Part ff. Other algnificant conditions contributing to death but not resulting in the undarlying cause givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably ð 24b. Ware autopsy tindings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yas 1 Tas 25. Was case rafarred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 1 Yas 2 No Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3 DOA 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Natural 5 Pending invastigetion 1 Natural 2 Accident 1 Yes 2 No 6 ☐ Could not be

the bunal-transit end Division of Vital Records. P.O. Box 68760. physician 8 for use as signed by t Deen page 2 s has certificate After

Funeral

Director

Item 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer Department of Health end Mentel Hygiene. Important: If ferm 27 is marked other than "natural", or the eny injury or other traumatic event, the stantant.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

the Marylend worle

> Be edical Certification:

or Attending Physician: after deeth. vithin 24 hour completely

State Registrar

29c. Licansa number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar es stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30-Nama and Addrass of person who complated cause of daath (Itam 23a) (Type, Print)

South Green Street

31. Dete filed (Month, Day, Year)

29b. Signature and fitta of certifia

3 ☐ Suicida

29a. Cartifier

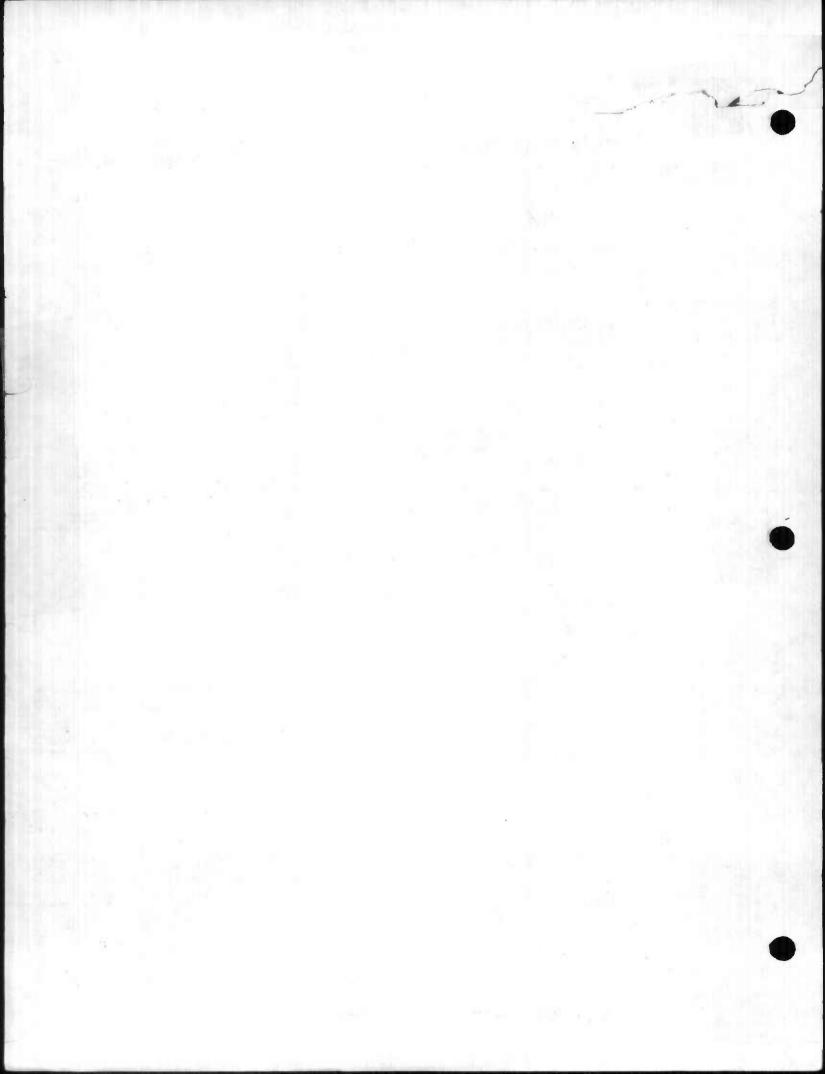
4 ☐ Homicide

(Check only one)

JAN 26 1999

22 32. Registrar's Signatura

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)



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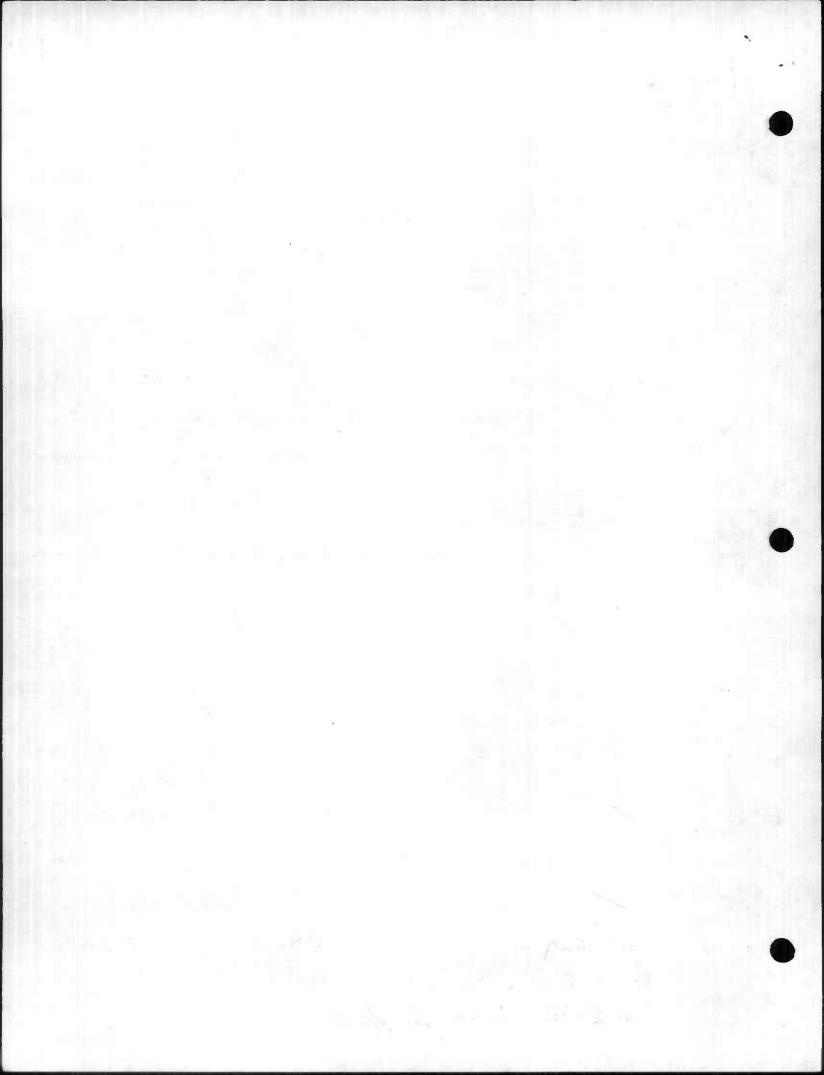
State of Maryland / Department of Health and Mental Hygiene 9 9 1 6 8 0

Item 8	Per	A.B. Film G767 1			Certificate of		Reg.			1000
Physic	cian	1. Decedent's Neme (First, Middle, I Myrtle K. And							/eer	3. Time of Deeth
/Med	lical						January		999	2:30 PM
Exam	iner	4a. Fecility Name (If not institution, g Citizens Nur				4b. City, Town, or Lo	Grace	4c. County of	ford	3
Funera Directo		Social Security Number 6.	Sex 7. A	ge (In yrs. las	t birthday) If Under 1 Ye Yrs. Months Da	ear If Under 24 Hrs. Lys Hours Min.	8. Date of Birth Month, Day, Ye May 24 New Jer	1908	9. Birthple Country	ce (State or Foreign y)
9		Usual Residence of Decedent					WEW DEE	bey I	vew_J	ersey
anyler thow	_	10e. State 10b. County			own or Location				100	d. Inside City Limits
M e M	Director	Maryland Harfor	d	Havr	e de Grace					1 ☐ Yes 21 No
deeth with the Maryland ms 23s or 28s-f show Linuit be notified at		415 S. Market	Street		10f. Zip Coo 210			Citizen of Wh.	at Country	N
Maryland 21215-0020 d 2 should be filed within 72 hours after deeth with the Maryler lith end Mentel Hygiene. 77 is marked other than "natural", or items 23s or 28s-f show the marked other than "natural", or items 53s or 28s-f show the marked other than be notified at	by Funeral	11. Maritel Stetus 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? No	13. Wes Decedent If Yes, specify C	of HispanIc Origin? (Spe Cuban, Mexican, Puerto No <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, et	
5-0 72 ho	Completed	15. Decedent's (Specify only highest g	ducetion		6a. Decedent's Usual Oc	ccupation	168	. Kind of Bush	ness/Indu	stry
2121 d within piene. r than "	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT use re	one during most of work! tired)				
Aaryland 2121 2 should be filed within end Mentel Hygiene, ls marked other then "	S	11	0		Buyer		(Gift Sh	ор	
be filed that the doctor	Be	17. Father's Name (First, Middle, Las				310000000000000000000000000000000000000	e (First, Middle, Mai	den Surname)		
arylan should be nd Mentel marked o	2	William J. Bank				Emma E.	Young			
Maryla d 2 should th end Mer 7 is marke treumatic		19a. Informent's Name/Relationship	(Type, Print)		19b. Mailing Address (Str	reet and Number or Rure	al Route Number, C	ity or Town, St	ate, Zip C	iode)
e, N 1 end 1 ealth m 27		UNKNOWN 20a. Method of Disposition		not Dis-	UNKNOWN	4				
Baltimore, M pemit. Peges 1 and 2 Depertment of Health e Important: if item 27 is any Injury or other tre		1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spec		com	e of Disposition (Name or etery, crematory or other	place)	Date 200	. Location - Ci	ity or Tow	n, State
Balt Permit. Depentingental Importal		21. Signature of Funeral Service Lice Ronald S.	Wade Dir	ector		dress of Facility latomy Board re, Maryland	•	Baltim	nore	Street
I Records, P.O. Box 68760, The law requires that the death certificate be executed the passion of the best been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b. Certe	Due to (or as	a consequence of): a consequence of):	Tive Ke	d d	drea	re	5 year
BOX.	icia	Part II Other aignificant conditions	contributing to death	but not regultir	a la tha undadvina acusa	akina in Dani I	22h Didtoha		Statuta an al	ha anuna id disab
P.O. the the detached	, Phys	Chimie	Cing	triu	The underlying couse	failer	1 Yes		Probe	he cause of death bly 4 - Unknow
Records, P.O. in law requires that the de has been signed by the ign 2 should be detached	Completed by	Degeneral	ire (with	ilis		24a. Was en a performed		eveil	e autopsy findings able prior to pletion of ceuse eth?
	Con						1 ☐ Yes	2000	10	Yes 2□ No
Vital I	Be	25. Was cese referred to medical examiner?				28. Plece of Death	(Check only one)			
of Vita Physician: this certific	10	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat		Outpatient 3LI DOA		me 5 Residence	e 6 □Other	(Specify)	
ision of the death.	ation:	27. Manner of Death 1 Netural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ay Year) 28		njury at 2 Work? 1 D Yes 2 DNo	28d. Describe how i	njury occurred		
Division Division The Hospital or Attending hin 24 hours after death. The Funeral Director: After npletely filled in by the fune	Certification:	3 Suicide 6 Could not determined	28e. Place of in building, e	jury - At home tc. (Specify)	, farm, street, factory, offi	ice 2	28f. Location (Stree City or Town, S		or Rural F	Poute Number,
Divi	edicai	29a. Certifier (Check only one) 1 Certifying P	hyaician: To the best miner: On the besis of and manner s	of exemination	dge, death occurred et the and/or investigetion, in m	e time, date and place, a ny opinion, death occurre	and due to the caused at the time, date	e(s) end mann and place, and	er as stat d due to th	ed. ne cause(s)
Within To the	Me	29b. Signature and the or cerumer		7.71	29c. Lic	ense number	29d.	Date signed (/	Month, De	ey, Year)
F 5 F 0		Illia	long	M	D. D1	5994		1-18-	99	
		39. Neme and address of person who		death (Item 23	a) (Type, Print)	mee M	1 A	1078	1	
St	ate	31. Date filed (Month, Day, Year) JAN 2 5 1990	32. Regist	rar's Signature	- Coe - CI	3 20 110	. 01	- , 0		
Regist	rar	JAN 2 5 1999	- Des	4	4 1					

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State of Maryland / Department of Health and Mental Hygiene 99 0 168 1

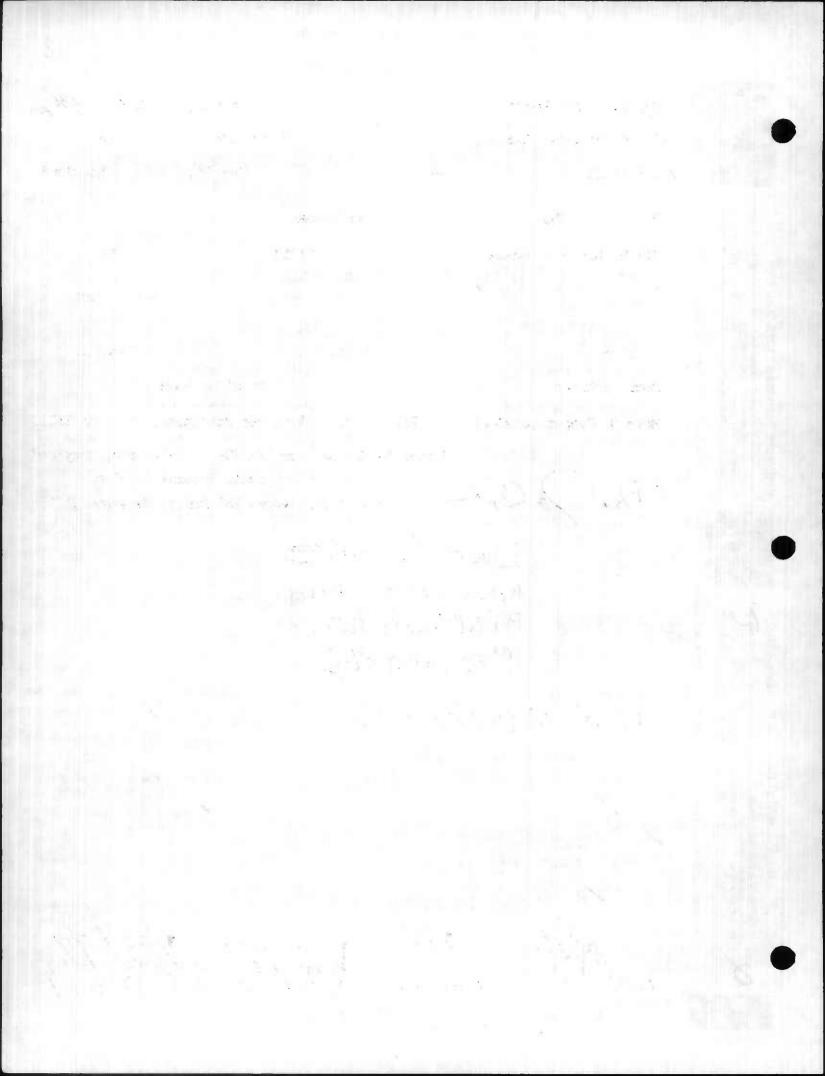
			Ciato of maryia			of Death		Reg. No.		
Physicia /Medic		1. Decedent's Neme (First, Middle, Last) Maggie Fr	arces Ba	KER	Bu		2. Dete of De Month	Day 19	Year 999	3. Time of Death
Examin		48 Facility Name (If not institution, give : 304 E. 20 ±				4b. City, Town, or BALLIA		h 4c. County	of Death	
Funeral Director		10-30 03/2	7. Age (In yrs. 63	last birthday) Yrs.	If Under 1 Months	Year If Under 24 Hrs Days Hours Min	. (Month, D.	th ay, Year) 935		lace (State or Foreign try)
after death with the Meryland or items 23e or 28e-f show or items 20 or 20 or 10 or	ctor	Usual Residence of Decedent 10a. State 10b. County Narykan	/A 10c. Ci	ity, Town or Loc		Ε			1	0d. Inside City Limite 1 Yea 2 No
th with th	al Director	304 E. 20 th S	Freet		10f. Zip (2/2/8		10g. Citizen of V		try?
1215-0020 within 72 hours after death with the Meryland one. than "netural", or items 23s or 28e-f show the Medical Exercition must be multified.	by Funeral	11. Merital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	I2. Wes Decedent Ever in L Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates:		as Decede Yes, specif	int of Hispanic Origin? (S by Cuben, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)	Specify	e - Americ ck, White,	
	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (9-12)	cation o completed) College (1-4or 5+)	1/	ind of work O NOT use	Occupation done during most of wo retired)	rking	16b. Kind of Br	0	
d be and	To Be Co	17. Father's Name (First, Middle, Last) HENRY PAHEI	son	1 7/00	30 /0.	18. Mother's Na	me (First, Middle	Maiden Syman	10)	
Mary and 2 sho afth and P 27 is me		19a. Interment's Name/Relationship (Ty BEDIA BILAL /	Daughter	19b. Meiling 3044		Street end Number or R				Code) el 2/223
Pages 1 nent of H int: If Her		20a. Method of Disposition 1. □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		Place of Disposicemetery, cremit	etory or oth	AC Parle	1-25-94	20c. Location -	AWN	Merylons
Baitim pemit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Liberton	io io	50	Name and	Address of Facility CA REIS TREAST LUNE, SEL	HATMA JOHN KI	an Nan	15 PC	INGEN HOME
Physician /Medical Examiner	70	23a. Part Énter the disease, or complianock, or heart tailure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	or as a consequ	Cel	of dying, such as cardia		irrest,		Approximate Intervat Between Onset and Death
68760, ficate be executed g physicien and as the buriet-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b							
687	v/Medical	cause (Disease of Injury that initiated events resulting in death) Last		or as a conseque	ence of):		7" NA NA			
death certing the attending and for use a	Physician/M	Part II. Other significant conditions con	tributing to death but not res	use given in Part I.	23b. Dtd tobacco use contribute to the cause of			the cause of death?		
	by Phy			1 Yes 2 No 3 Probably 4 L			pebly 4 Unknow			
of Vital Records, Physicien: The law requires the this certificate has been signe tel director, page 2 should be a	Completed						24a. Was perf	an autopsy ormed?	eva	ere eutopsy tindings alleble prior to mpletion of cause death?
Vital Re licien: The li certificate he rector, page		25. Was case reterred to medical	1 ☐ Yes 2 26. Place of Death (Check only one)							Yes 2□ No
Of Vita Physicien: this certific	To Be	examiner? 1 Yea 2 No	ospital: 1 Inpatient 2	ER/Outpatient	3 DO/	Other	1	idence 6 Oth	er (Specify	y)
Division or attending Ph and or attendenth. I Director: After this d in by the funerel		27. Manner of Death 1 Neturel 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28d. Describe how injury occurred						
	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy)	n (Street end Number or Rural Route Number, Town, State)					
Hospital 24 hours a Funeral letely filled	edicai	29a. Certifier (Check only 2 Medical Examinone)	ician: To the best of my known: On the basis of examine and manner stated.	owledge, death of etion and/or inve	occurred el estigetion, i	the time, date end place n my opinion, deeth occ	e, end due to the urred at the time,	ceuse(s) and ma date end place,	anner as si and due to	ated. the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	M		29c.	License number	54	29d. Date signe	/ /	9ey, Year)
7		30. Name and address of person who con	mpleted cause of death (Item	m 23a) (Type, P	rint)	Baltien	21	202		4.4.4
Stat Registra		31. Date tiled (Month, Day, Year)	32. Registrar's Signa	ature 4	1					



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					Certificate of	of Deati	h	Re	g. No.		
	Physician /Medical	1. Decedent's Name (First, M Sheila Amar						2. Date of Deet Month January	h	999	3. Time of Death
	Examiner	4a Facility Neme (If not institute 1513 N. Mont		or)	Balti				4c. County of Death N/A		
	Funeral Director	5. Social Security Number 216-86-1323 Usuel Residence of Decedent	1□M 2 ½ F	Age (In yrs. lest birth		eer If Unders	er 24 Hrs. Min.	8. Date of Birth (Month Day, May 04,	1961	9. Birthp Coun	lace (State or Foreign (ry) aryland
	5-0020 72 hours effer deeth with the Maryland natural; or items 23a or 28a-f show or all Examples in notified at each or by Funeral Director		10a. State 10b. County 10c. City, Town or Location							1	0d. Inside City Limits 1 Yes 2 No
		10e. Street and Number 1513 N. Mont	1	0g. Citizen of t	What Coun						
020	ral, or items Examiner in	11. Merital Stetus 1 Never Married 2 N 3 Widowed 4 Divor	If Yes Give	s? No	13. Was Decedent If Yes, specify (of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.) No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		etc.
21215-0020	ed within 72 hours ygiene. nor than "natural", rt, the Mad sal East rt, the Mad sal East Completed by	(Specify only high	15. Decedent's Education (Specify only highest grede completed)			16a. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)				usiness/ind	dustry
	Hygiene. The than mit, the Me	Elementery/Secondary (0-1	Elementery/Secondary (0-12) 10th College (1-4or 5+)							Domes	tic
Maryland	d out	17. Father's Name (First, Mide Jack Matthe				18. Mot		ne (First, Middle, M saline B		ne)	
	2 4 4 4	19e. Informant's Neme/Releti	ionship (Type, Print) oper (Sister)		Mailing Address (St. 22 E. Fed						
Baltimore,	Pagas 1 end nent of Health nt: If item 27 iry or other to	20a. Method of Disposition 1 → Burial 2 □ Cremati 4 □ Donetion 5 □ Othe	on 3 Removal from Star r (Specify)	cemeters	Disposition (Name of cremetory or other L1's Mem (plece)	s 1/2		Baltin		wn, State Maryland
Balti	permit. Pages Department of Important: If i any injury or once.	21. Signatura of Funeral Serv	3 Can	2	22. Name and Ad 5502 Wir	nner Av	venue	ple Fune Baltimo	re, Ma		d 21215
200	Physician /Medical Examiner	shock, or heart failure. Immediate Ceuse (Final disease or condition resulting in death)	a.	Due to (or as a c	ülur			or respiratory em	551,		Approximete Interval Between Onset and Deeth
x 68760,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	{ · ma	Due to (or as a co	onsequence of);	h h					
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Vital Records,	been s should							24a. Wes a perform		ev	ere autopsy findings eilable prior lo impletion of cause deeth?
al Re	- U				19.			1□ Ye	es 2 No	10	□Yes 2□ No
Vita	Physicien: The rhis certificate ral director, page Co	25. Was case referred to med examiner? 1 Yes 2 No	Hospital:	utient 2 ER/Out	patient 3 DOA	Other:	ice of Dee Nursing H	oth (Check only on		ner (Specif	6/1
Division of	유 등 등	27. Menner of Deeth 1 Naturel 5 Per 2 Accident	nding (Month, L			Injury et Work? 1 Yes 2		28d. Describe ho			7)
Divis	tal or Attending P rs after death. all Director: After t led in by the funer: Certification:	3 Suicide 6 Co	uld not be ermined 28e. Placa of building,	Injury - Al home, far etc. <i>(Specify)</i>	m, street, factory, of	fice		28f. Location (Si City or Town	treet end Num n, State)	ber or Rure	el Route Number,
	To the Hospital or Attending Into the Hospital or Attending Into 24 hours after death. To the Funeral Director After completaly filled in by the fune. Medical Certification	29a. Certifier 1 Certi (Check only 2 Medione)	fying Phyalcian: To the bes cal Examiner: On the basis and menner	of examination and	deeth occurred al th /or investigation, in r	ne time, dete my opinion, d	and placa eath occu	, and due to the co rred at the time, d	ause(s) and m ate and place,	anner es s and due to	tated. o the cause(s)
	To the com	29b. Signature end title of our	The same of the sa	MI	29c. Lie	cense numbe	52	706	9d. Date stone	6 (Month)	(Dey, Year)
	8	30. Name and address of p	CATHED	death (Item 23e) (Type, Print)	SHER	un	ore N	ID &	2/2	101
	State Registrar	31. Dete filed (Month, Day, You JAN)	2 6 1999 32. Regis	st ar's Signature	B. So	racks	,				,

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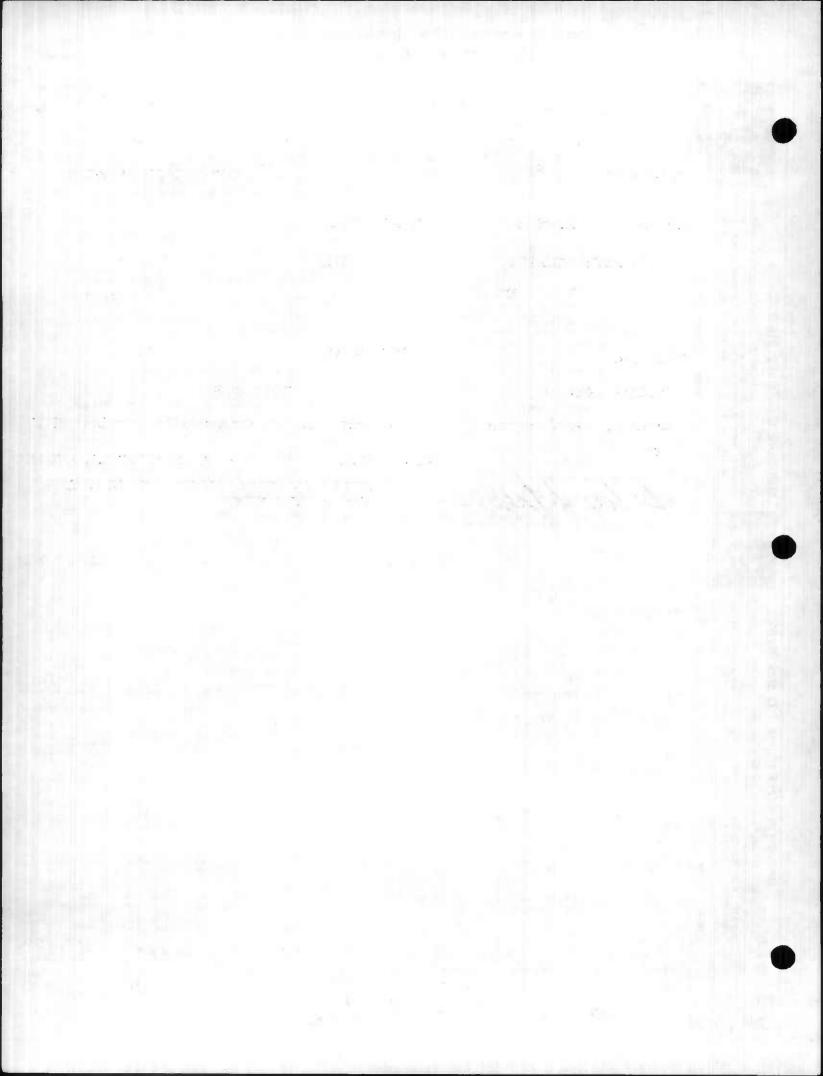


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 20 **Physician** William Blake 4b. City, Town, or Location of Death /Medical 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Baltimore Hospital Dina N/A If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6 Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 18 M 2□ F 72 Yrs. Director OCT 23 1926 MARYLAND 214-20-1342 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examinar must be notified at 1 ☐ Yes 2 XX Directo MARYLAND BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 4627 KINGS MILL WAY 21117 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 √Yes 2 No If Yes, Give Yaar or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0020 1 ☐ Yes 2 ☐ Specify: Specify: BLACK þ 30XWidowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER GSA 10th grade 18. Mothar's Nama (First, Middla, Maiden Sumame) 17. Father's Name (First, Middle, Last) h end Mantal I should be WILLIAM SATCHELL MYRTLE BLAKE 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 end 2 Department of Health en Important: if frem 27 is any injury or other treu 4627 Kings Mill Way, Owings Mills, Maryland 21117 Marsha A. Owens/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XXurial 2 □ Cremation 3 □ Ramoval from State DULANEY VALLEY 1-26-99 COCKEYSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility WIILIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in death) one week pheumonia Examiner Due to (or as a consequence of) Examiner Seizures attanding physician and for usa as the buriel-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical Due to (or es a consequence of) SB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown cevebral vascular accident Division of Vital Records. à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 has 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 28a. Date of Injury (Month, Day Year) uneral 27. Mannet of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending Investigation after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide 6 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completaly (Check only one) To the I within 2 To the P 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lliams, m! npleted cause of death (Item 23a) (Type, Print) Hospital 2401 W. Belvedere Ave MD Sinai Williams

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year) JAN 26



The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760,

attanding physician and for usa as tha bunal-transit signed by the a cartificata has b Aftar this Director: Aftar thi Hospital or Attending 24 hours after death. 24 hours To the Hosp within 24 hor To the Fune complataly fi

Physician

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Examiner

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Funeral

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permit. Pagas 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Health and Mantel hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at

Physician

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Examiner

Physician/Medical Examiner

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Certification:

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3 Suicide

29a. Certifier

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29b. Signature end title of certifier

31. Date fited (Month, Day, Year)

altimore, Maryland 21215-0020

State Registrar

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6 Could not be determined

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12 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

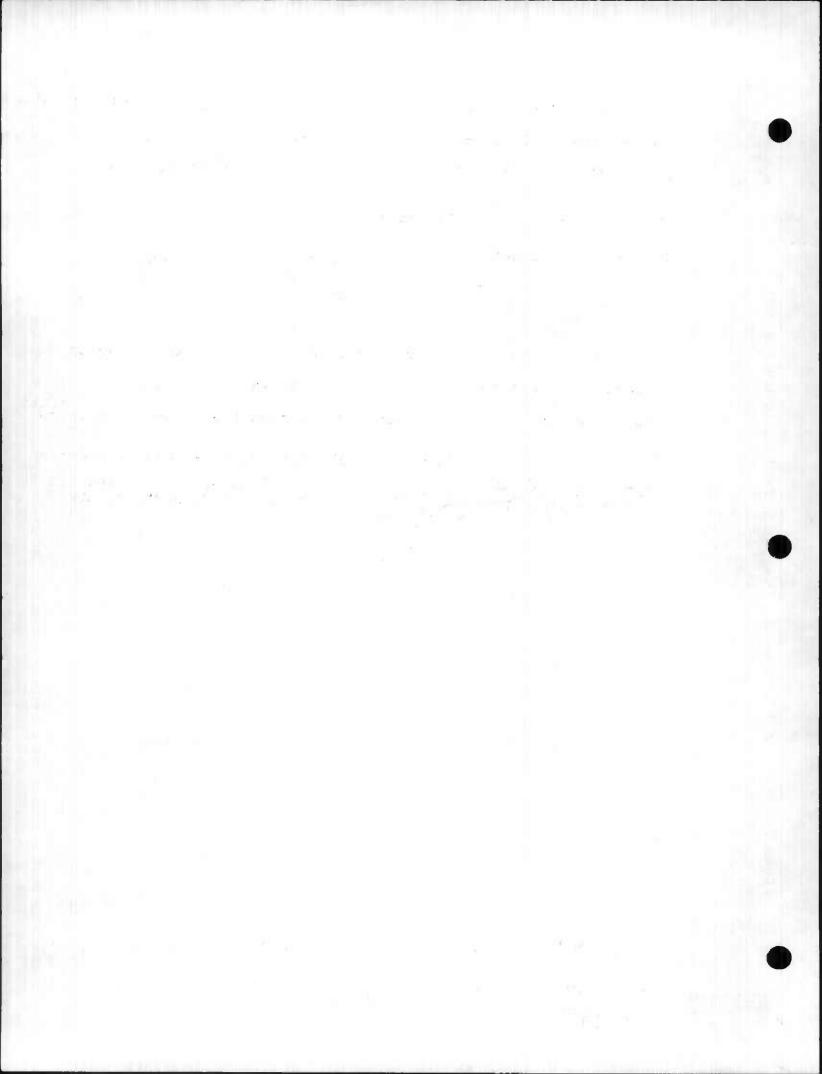
1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

HARBOR 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

HOSPITAL CENTER



Physician /Medical

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mantal Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

To

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		of Maryland	d / Depa		of Health a	and M	Mental Hy	0	9 01685
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4a Facility Name (If not institution	n, give street and m	um <i>ber)</i>					ocation of Death	1	
BEATON UNIVER	KSITY OF	marylo	and K	Medicine		Himo	3510	7	n/a
5. Social Security Number	6. Sex	7. Age (In yrs. le) If Under 1 Ye Months Da	ear If Under	Min.	8. Date of Birt (Month, De	th ev. Year)	Birthplace (State or Foreign Country)
219-26-8542	1□ M 2 K2 *	6	50 Yrs.	Process	lys		Jan.2,	,1939	MD
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MD r	n/a			imore					iXIXes 2□No
10e. Street and Number 1625 Lorman	Ct.			10f. Zip Cod	217			10g. Citizen of V	What Country?
11. Marital Status 1 ★★ ver Married 2 Marri 3 Widowed 4 Divorced	Armed For	2 XXX Give		Was Decedent of Yas, specify C	Cuban, Maxican	n, Puarto	ecify Yes or No- Rican, etc.)		ca - American Indian, ack, White, etc.
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Elamentary/Secondary (0-12)	Collega ((1-4or 5+)						3mori	can Rescue
17. Father's Name (First, Middle, I	f act)		Face	tory W		er's Nam	e (First, Middle	Americ , Maiden Suman	
	awrence				Cora		Stephen		ne,
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he	rate fai	ilure					10	Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		1-,				e of Deat	th (Check only o	one)	
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27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	gation	e of Injury onth, Day Year)	28b. Time o Injury	1	Injury et Work? 1 Pes 2		28d. Describe	how injury occur	rred
3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 289. Place	ca of Injury - At hou	me, farm, st	reet, factory, off	lice		28f. Location (S City or Tox	Street and Num wn, State)	nber or Rural Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burier-flagit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only

29b. Signat

State

Registrar

29c. License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

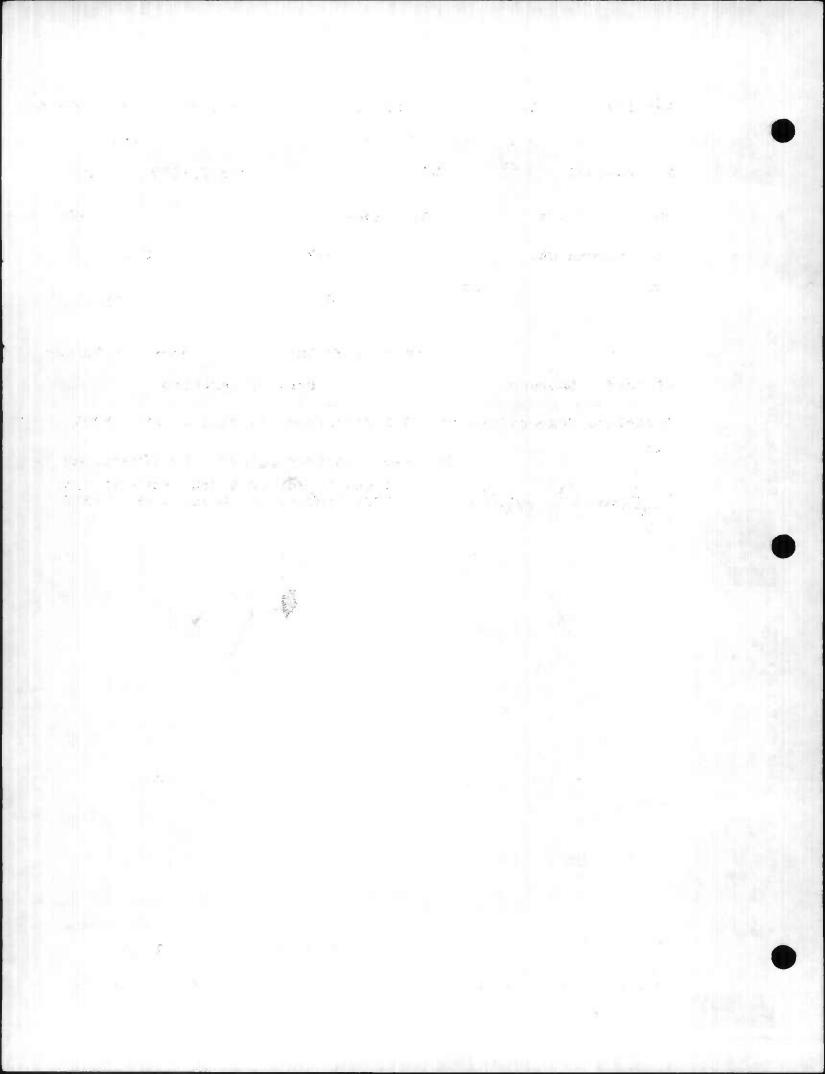
21230 JOEL BALTMORE

31. Desembled (Month, Day, Year) JAN 26 1999

are and title of certifie

32. Registrar's Signeture

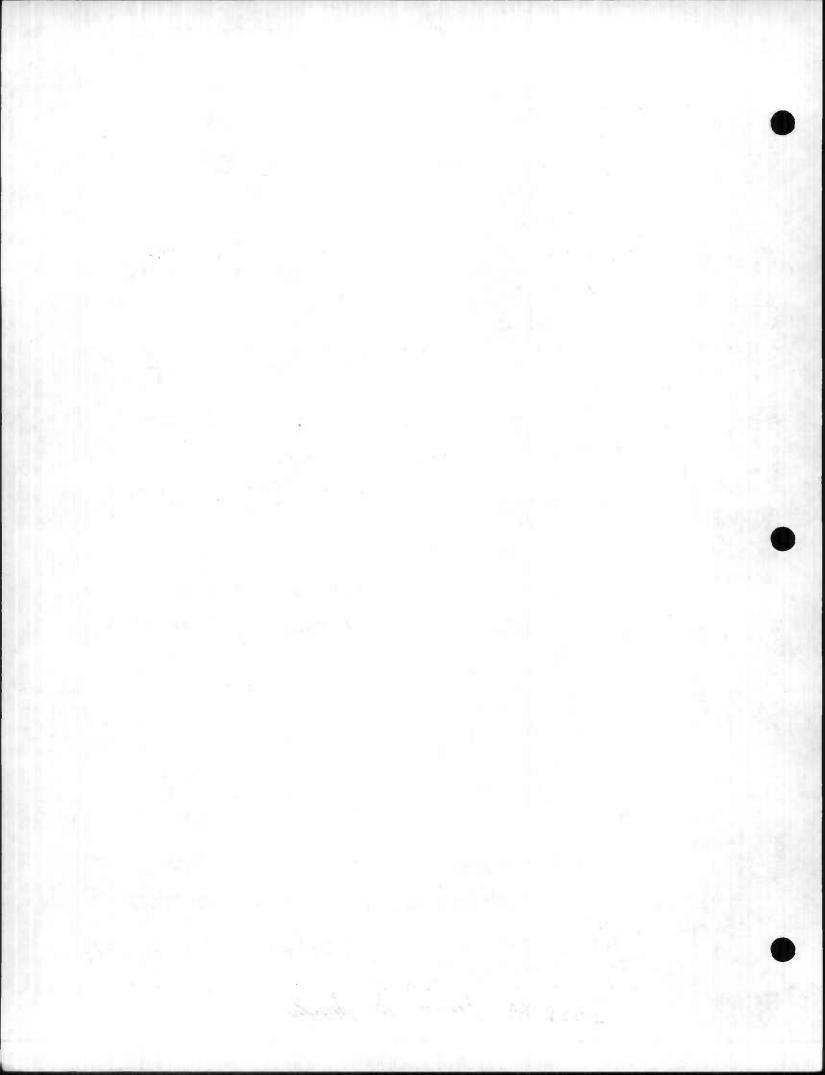




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State of Maryland / Department of Health and Mental Hygiene 99 01686

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/Medical	HUGH BENET				23 199	9 7	:25pm			
Examiner	4a Facility Name (If not institution, give	re street and number)				4b. City, Town, or	Location of Death	4c. County	of Death	
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Funeral Director	5. Social Security Number 6. S 152-22-2964 Usual Residence of Decedent	MAN OF	n yrs. last birti	rs. If Und Month	er 1 Year S Days	If Under 24 Hrs Hours Min.		y, Year) /1921	9. Birthplace Country) TENNE	(State or Foreig
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her death ther must sher must Funeral	11. Merital Status	12. Wes Decedent Ever in U.			J.S. 13. Was Decedent of Hispanic Origin				14. Race - American Indien,	
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	30. Name and address of person yello	completed cause of death	(item 23a) (1	ype, Print)					-111	
	CARL SPERLIN				EN T	BLVD. B	AT TO N	ID 212	20	
State	31. Date filed (Month, Day, Year)	32. Registra/s	Signeture	L			TITU . IV	ID. 212	39.	
Registrar	IAN 2.5	1999 \ 0	neva	D.	100	uls				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 0 0 5:20 Pm January 21, 1990 cation of Deeth | 4c. County of Death 1999 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 12/18/ Social Security Number 219-07-7278 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign) **Funeral** Months Days Hours Virginia 1⊠M 2□ F 79 187 Yrs **Director** Usual Residence of Decedent with the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at N/A BALTIMORE 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A. 3311 Bateman Avenue Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Reca - American Indien. 11. Maritel Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried 1 ☑ Yes 2 ☐ No If Yes. Give 1 Yes 2√ No Specify: Black P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Morgan State Elementary/Secondary (0-12) College (1-4or 5+) Hygiena. Master Plumber 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be nent of Health end Mental Henry Thomas Bailey Pearl Lee Mears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) nt of Health e if item 27 la Theresa E. Bailey 3311 Bateman Avenue, Balto., MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Arbutus Memorial Park1/27/99 Arbutus, MD 4 ☐ Dogetion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 Efter the disease or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one ceuse on each in Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Seriis touns disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner 42215 Chrolionyopathy that the death certificate be executed physician end the buriel-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): as USB 0 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Concer of the Prostote 1 Yes 2 No 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en autopsy Completed Anyio dysplasio has SIRMITAN volve replacement 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No cartificata 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To examiner? Hospital: 1 ☐ tnpatient 2 ☐ ER/Outpetient 3 ☐ OOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: Aftar or Attending 1 DNatural 5 Pending after deeth. 1 Tyes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 Homicide 24 hours Hospital edicai 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end menner as steted. completely 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner stated. (Check only To the within 2 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 122031 1-22-99 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

JAN 2 6 1999

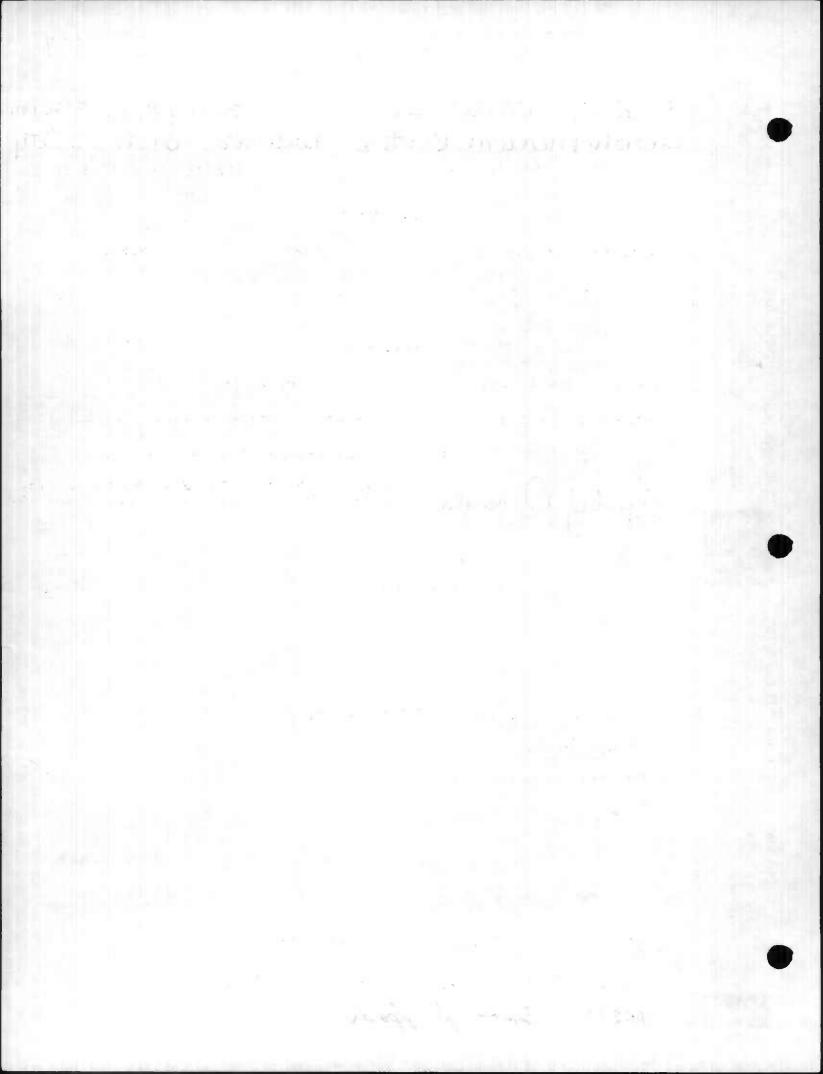
31. Date filed (Month, Day, Year)

Lanny S. Venny

2116 many land you 32. Registrar's Signature

1.1.

Bato md. 21218



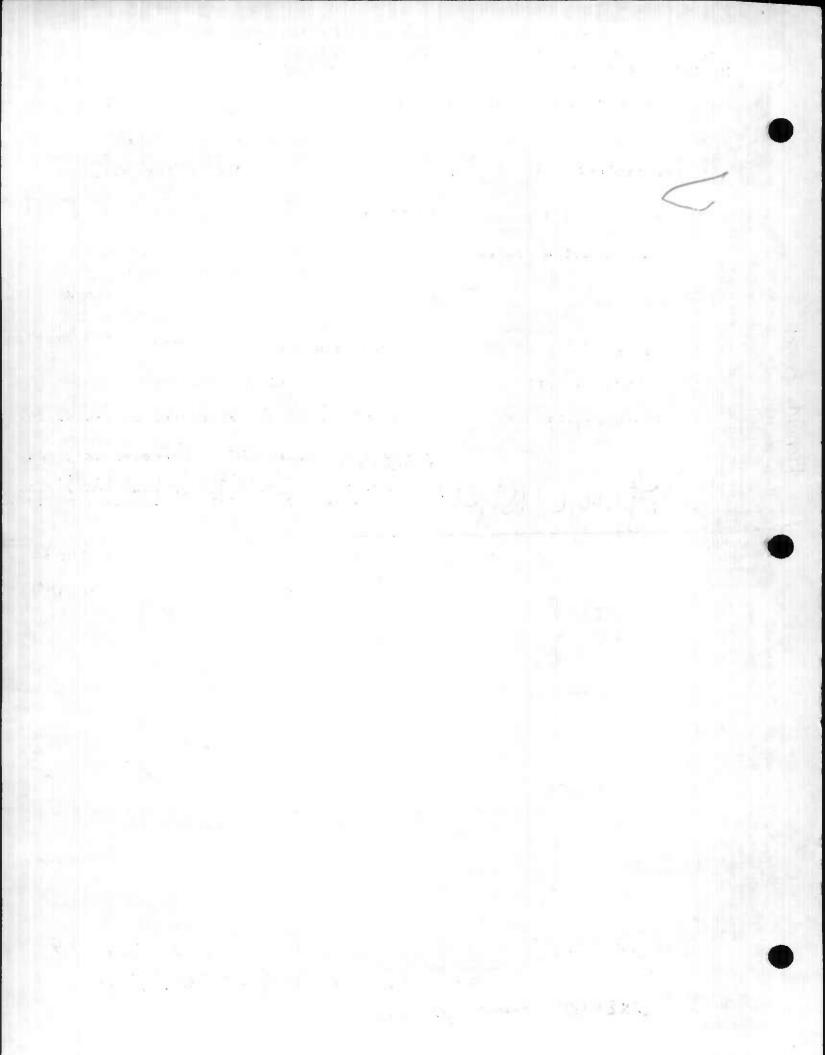
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Item: 20b, c per F.H G-768 2/16 state of Maryland / Department of Health and Mental Hygiene 99 Item#12,20b perFHG768 2/12/99 EW Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month 1009 **Physician** RICHARD ERNEST BURRELL, SR. 11:15 am 24 /Medical 4a Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Sinal Hospital Balhmore 8. Date of Birth (Month, Dev. Year) 05/18/1926 5. Social Security Number 6. Sax If Undar 1 Yaar If Under 24 Hrs. 9. Birthpiaca (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Country) Virginia Months Hours 187M 2□ F 220-14-0133 72 Director Usuai Residence of Dacedant 10e State 10h County 10c. City, Town or Location 10d Inside City Limits ms 23a or 25a-f show must be notified at MD N/A BALTIMORE 1X Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 U.S.A. 2023 Clifton Avenue Herns 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. the Medical Examiner I Ki Yes 28100 If Yes, Give 9/46-10/46 Yaar or Datas: 9/46-10/46 1 Never Married 2 Married Black 1 Yes 2₺ No Specify: Specify: À 3- Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiece. U.S. Postal Service Elementary/Secondary (0-12) Coilege (1-4or 5+) Route Examiner 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Montai Samuel Burrell Flora Midgette marked and y 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 3421 Ripple Road, Baltimore, Maryland21207 Rosing White mportant: If Item 27 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State LAUREL ALDULUS, 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Park1/29/99 Arbutus Memorial MB National Park Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Lic 22. Nama and Address of Facility Willie Howell LEROY O. DYETT & SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 or complication. This canced the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, st only one cause on what line. Approximate Interval Between Onset and Death **Physician** /Medical immediete Ceuse (Final Respiratory Failure 2 WELKS disaasa or condition resulting in death) Examiner Examiner Metastatic Bladder Cancer 10 months law requires that the deeth certificate be executed and -trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician a Box 68760 Physician/Medical Due to (or as a consequence of): attending p 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the signed by t 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen ate hes The 1 Yes 2 No 1 Yes 2 PNC certificate : After this certification and funeral director, or Attending Physician: 25. Was case referred to medical Be 26. Piace of Death (Check only one) Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Inpatient 1 Yas 2 IN Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Hatural 5 Pending deeth. Investigation 1 ☐ Yes 2 ☐ No 2 Accident ofter deeth Director: / 6 Could not be 3 Suicida 28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) end manner stated. 29a. Certifier edicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier 201 mu eted cause of death (item 23a) (Type, Print) Inter-

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

Richard



DHMH 16 Rav 6/95

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Registrar

31. Dete filed (Month, Dey, Year)

JAN 26 1999

32. Registrar's Signeture

NAME KNOWN TO PHYSICIAN

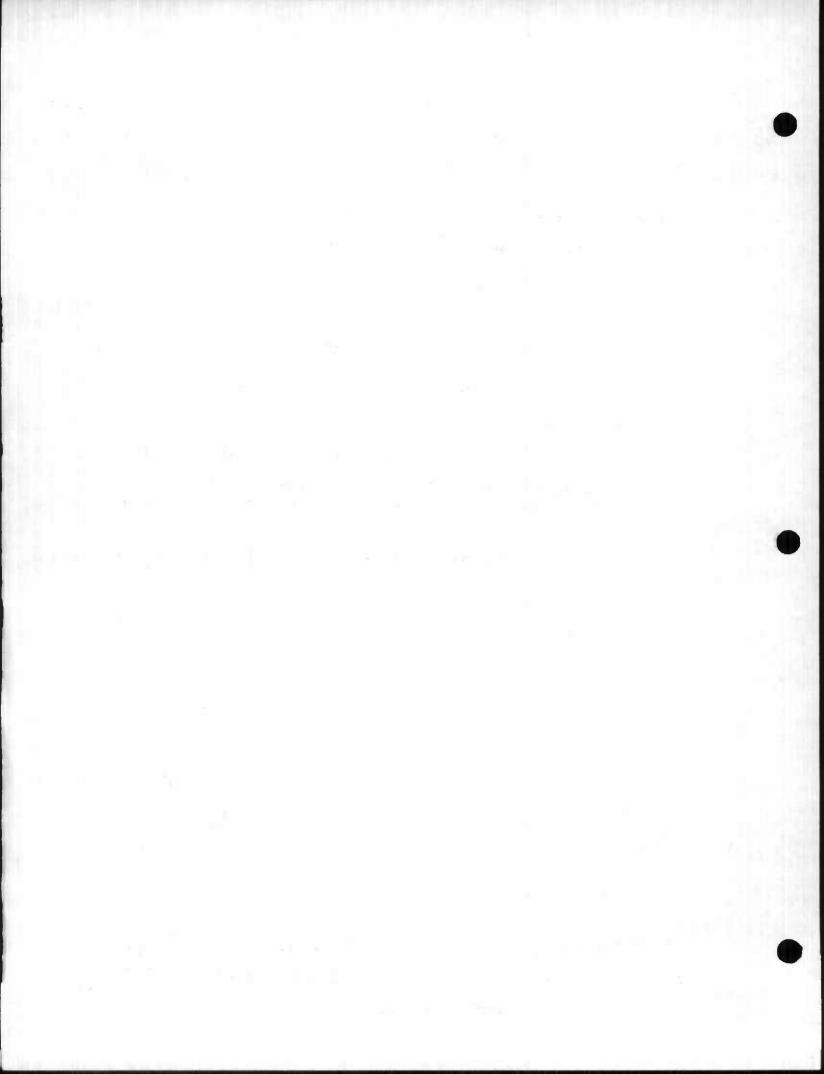
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth 25°, **Physician** JAN. 1999 6:30am Nevabelle Blum /Medical 4a. Facility Name (If not institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 8004 Douglas Avenue Baltimore if Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) if Undar 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** 1□ M 2 F Days Months 77 190-12-0212 Yrs. Director DEC. 14, 1921 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits ns 23a or 28a-f sh 1 Yas 2 No Baltimore Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21244 8004 Douglas Avenue items 23a permit. Pages 1 and 2 should be filed within 72 hours efter death a Depertment of Health end Mentel Hygiene. Important: if item 27 is merked other than "natural", or items 28s any injury or other traumatic event Funeral 11. Marital Status 12. Was Decedent Evar in U,S. Armad Forcas? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - Amarican Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Yes 2V No 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Year or Dates: White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 6 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Vernon C. Bankert 20 Elsie Forry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Eldersburg, MD 21784 6739 MacBeth Way Tunya M. Justice/daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Neme of Date 20c. Location - City or Town, State Metro Crematory, Inc. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 1/26/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Service Licansea 22. Nama and Address of Facility Cremation Society of Maryland Inc. McDonald Male 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disaase, or complications that ceused the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) ue pulmonary disease Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed and the burial-trar Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that let it and event in the let it and event in the let it it and event in the let it it and event in the let it. Due to (or as a consequence of) Box 68760, ettending physician Physician/Medical that initieted events resulting in death) Last Due to (or as a consaguanca of): signed by the Division of Vital Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24e. Wes an eutopsy performed? peen : this certificate has 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No Physician: director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No s effer death.
Il Director: Affer this ad in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Yaer) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Attending 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Streat end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 0 To the Hospital o within 24 hours ef To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as steted.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end manner stated. Medicai 29a. Certifier 29b. Signature and title of certifiar 29c. Licansa number 29d. Date signad (Month, Day, Yaar) 1125 30. Name and address of person who combleted cause of death (Hem 23e) (Type, Print)
TAHOORA KAWAJA 1777, Raistertown Rd #108 Baltanese
MD 2120

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)
JAN 2 6 1999

32. Registrar's Signature

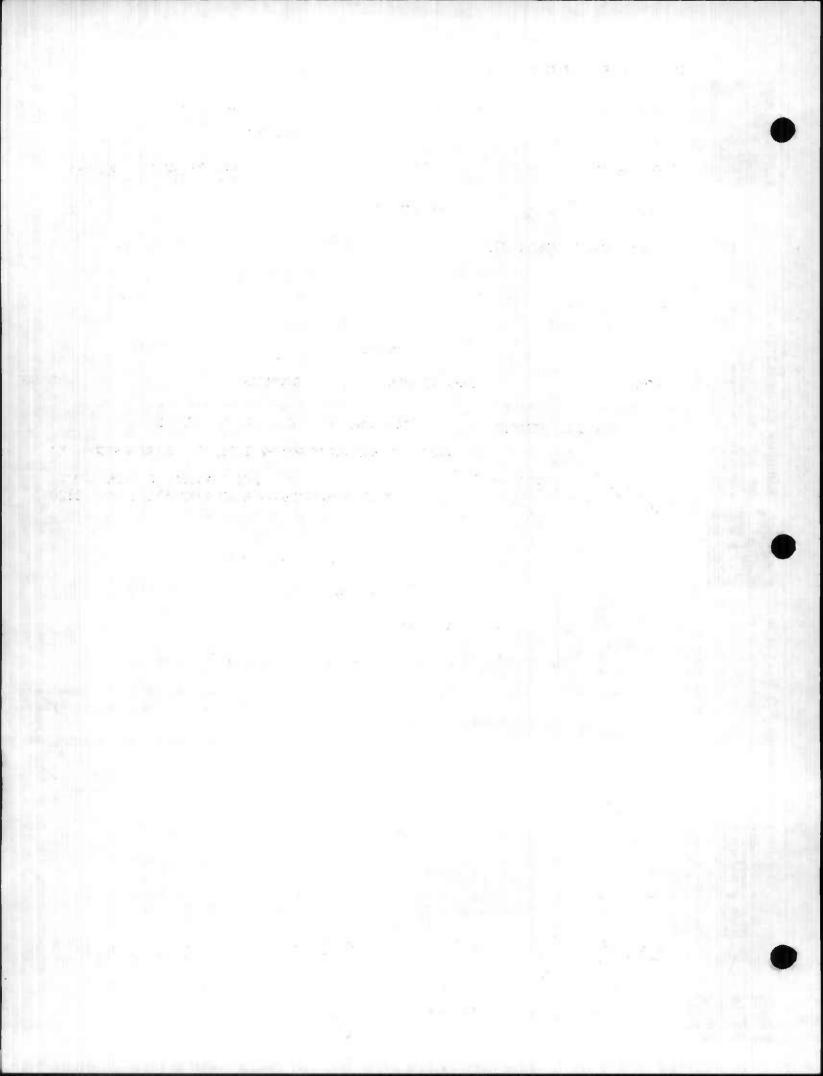


attending physician and for use es the buriel-trans P.O. Box 68760. 88 Division of Vital Records. page 2 s has After this funeral (

State of Maryland / Department of Health and Mental Hygiene Q Item: 8, per F.H G-7671/26/99 reb Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month 1999 Physician 10:10 pm BAKALRYCHIK Lanuary TAMARA /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) BALTIMORE Hospital of Baltimore If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth MAR 21 1921 Mar. 8, 1921 5. Social Security Number 9. Birthplace (Stata or Foreign 6. Sax 7. Aga (In yrs. last birthday) Days Hours Min 1 M 20 F RUSSIA 215-92-5596 77 Yrs. Usual Rasidance of Dacedent 10b. County 10c. City, Town or Location BALTIMORE 10d. Inside City Limits 1 Yas 2 No 10f. Zlp Coda 21215 10g. Citizan of What Country? 10e. Street and Number 3615 FORDS LANE # 311 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Marriad 2 Married 1□ Yas 2□No Specify.WHITE Specify: 3€ Widowad 4 Divorced 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) CRAFT DESIGNER 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) **ITCHAK** BAKALEYCHIK REBECCA 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Steta, Zip Code) permit. Pages 1 and 2: Department of Health er Important: If Item 27 is 2418 HUNT DR. BALTIMORE MD 21209 SHEVCHUK /DAUGHTER 20b. Place of Disposition (Nema of Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition BALTIMORE HEBREW 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata CEMETERY 1/21/99 REISTERSTOWN MD. 4 □ Donation 5 □ Othar (Specify) 21. Signature of Fungel Service Lies 22. Nama and Addrass of Facility SOL LEVINSON & BROS. INC. 21208 8900 REISTERSTOWN ROAD PIKESVILLE MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only offe cause on each line. Approximate interval Between Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Multi-System Organ Failure Due to (or as e consequence of): Examiner Hepatic Failure Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Dua to (or as a consaquance of) Renal Failure Physician/Medical Dua to (or as a consequence of): Metastatic Cancer-Unknown Primary 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 NO 1 Yas 2 No 25. Wes case refarred to medical axaminar? Be 28. Placa of Death (Chack only ona) 1 Yas 2 No Hospital Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 28a. Data of Injury (Month, Day Yaar) 27. Menner of Death 1 ☑ Naturel 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 ☐ Yas 2 ☐ No 24 hours efter death. 2 Accident 6 Could not be datermined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, ferm, streat, factory, office building, atc. (Specify) filled in by 4 Homicida Hospital 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and placa, end due to tha causa(s) end mannar as steted. edicai 2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. (Check only one) within 2 To the the 29c. Licansa number 29b. Signature and title of certif 29d. Data signed (Month, Day, Year) PhD, DO January 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print) Shelley A. Quarless, PhD, Do, 2401W Belvedere Ave, Baltimore, MD 21201 32. Ragistrar's Signatura 31. Data filed (Month, Day, Year) State JAN 26 1999

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permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23, any injury or other traumetic event, the Medical Examples must

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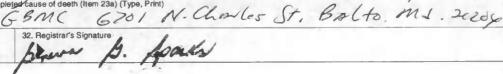
29a. Certifier

(Check only one)

29b. Signature and title of certifies

JAN 2 6 1999

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address of person who completed cause of deeth (Item 23a) (Type, Print)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

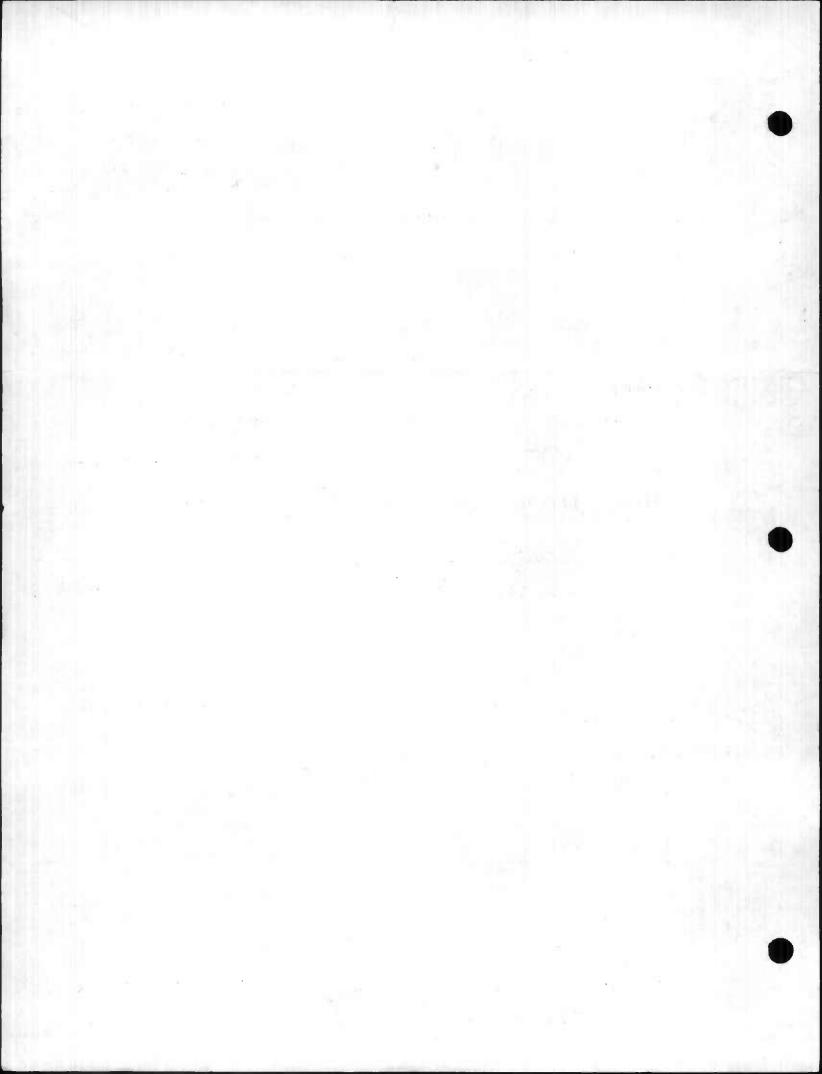
29c. License number

29d, Date signed (Month, Dev. Year)

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Edward Bmil Blazek January /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 46. Examiner Baltimore HOS enter Kosedale manklin Sallare Dita If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 504-07-2912 1 M 2 F Markus, South Dakota Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 ☐ Yes 2 ☐ No Director Baltimore County - White Marsh Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5804 Carrington Drive 21162 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Mental Status Black, White, etc 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Specify. à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) then College (1-4or 5+) dwaro Engineer Glen L. Martin Department of Health and Mental Hygis Important: If Itan 27 Is marked other t any Injury or other trauments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Emil Blazek Mary Hlavka 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma M. Blazek (Wife) 5804 Carrington Drive White Marsh, Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. January 19, 1999 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Lassahn Funeral Home 21. Signeture of Funeral Service Licensee 7401 Belair Road Baltimore, Maryland 21236-4625 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting In death) Examiner Due to (or es a consequence of): Examine 1110019 physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Physician/Medical Due to (or as e consequence of): P.0. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown sease Division of Vital Records. þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed MyoCardia Infarction | 12.00
26. Place of Deeth (Check only one) Nephrectomy. 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to nedicel axaminer? Hospitel Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpetient 3 ☐ DOA 1 Inpatient 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Netural 2 Accident 5 Pending Investigation s after dec. 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homiclde 6 To the Hospital o within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 9 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Baltimore, MD 2/237 9000 Franklin Squar Dr Grace lana 31. Dete filed (Month, Day, Year) 32. Registralis Signature State JAN 26 1999 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month BENTSIS JANUARY 21, 1999 SVIRA 14:30 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death HOSPITAL BALTIMORE OF BALTIMORE If Undar 24 Hrs. 8. Dete of Birth MAR 27 Year 31 If Under 1 Yaar Months Days 7. Aga (In yrs. lest birthdey) 9 Birthplece (State or Foreign 5. Social Security Number 1□M 2√2F RUSSIA 67 218-45-0539 Yrs. Usuel Residence of Decedent 10b. County BALTIMORE 10d. Inside City Limits 10c. City, Town or Location BALTTMORE 1 ☐ Yes XX No 10f. Zip Code 21215 10g, Citizen of Whet Country? 10e. Street end Number 4 AMLEHT COURT APT. 1-B 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas ZW No If Yes, Give Yaer or Datas: 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 11. Merital Stetus SpeciWHITE 1 Navar Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) CLOTHING COMPANY 12 TAILOR 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middla, Last) FAYNBERG SOKOLYAR FILLYA IDA 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) MEYER BENTSIS /HUSBAND 4 AMLEHT COURT APT. 1-B BALTIMORE MD 21215 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete 20a. Method of Disposition AREINGTON CEMETERY/CHIZUK Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) JAN 22/99 BALTIMORE MD AMUNO CONGREGATION 21. Signeture of Funerel Service Licenses 22. Name and Address of Fecility SOL LEVINSON &BROS INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD 21208 ola 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximata Intarvel Between Onset and Deeth Immediete Ceuse (Finel diseese or condition rasulting In deeth) . MYOCARDIAL INFARCTION WITH CARDIOGENIC SHOCK ORONARY ARTERY DISEASE Due to (or es e consequence of) HYPERTENSION Dua to (or as a consequenca of): YEARS IABETES 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24e. Wes en eutopsy completion of cause of deeth? 2 No 1 ☐ Yas 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) 1 Inpatient 2 □ ER/Outpatlent 3 □ DOA

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permit. Pagas 1 and 2 sh Department of Haaith and Important: If Item 27 Is in any injury or other traun once.

Baitimore, Maryland 21215-0020

Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Physician/Medical

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medical examiner? Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27 Manner of Deeth 28b. Time of 28c. Injury et Work? 1 Netural 5 Pending Investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide

29e. Certifier (Check only one)

1 🗶 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifie

29c. Licensa number

29d. Date signed (Month, Day, Year)

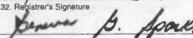
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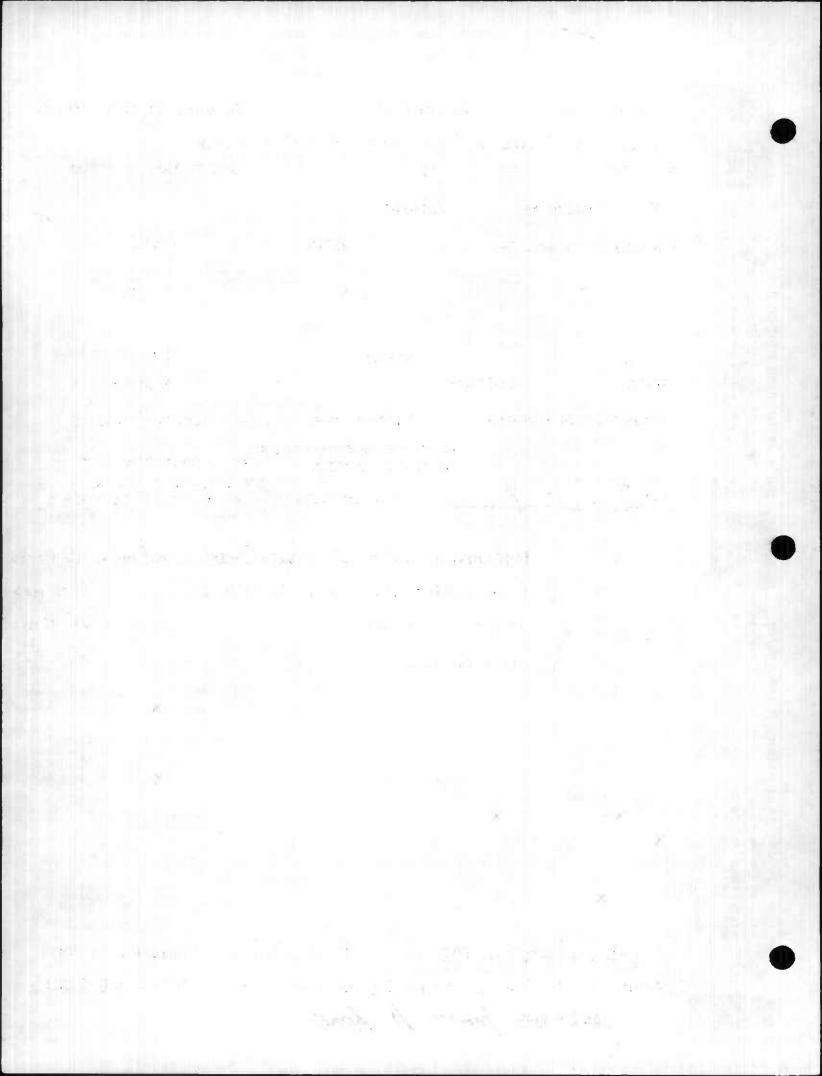
30. Name and accress of person who completed cause of deeth (Item 23e) (Type, Print)

JOSEPHINE OMUSU-SAKYI , 2401 WEST BELVEDERE AVE, BALTIMORE MD 21215 31. Dete filed (Month, Dey, Year)

State Registrar

JAN 2 6 1999

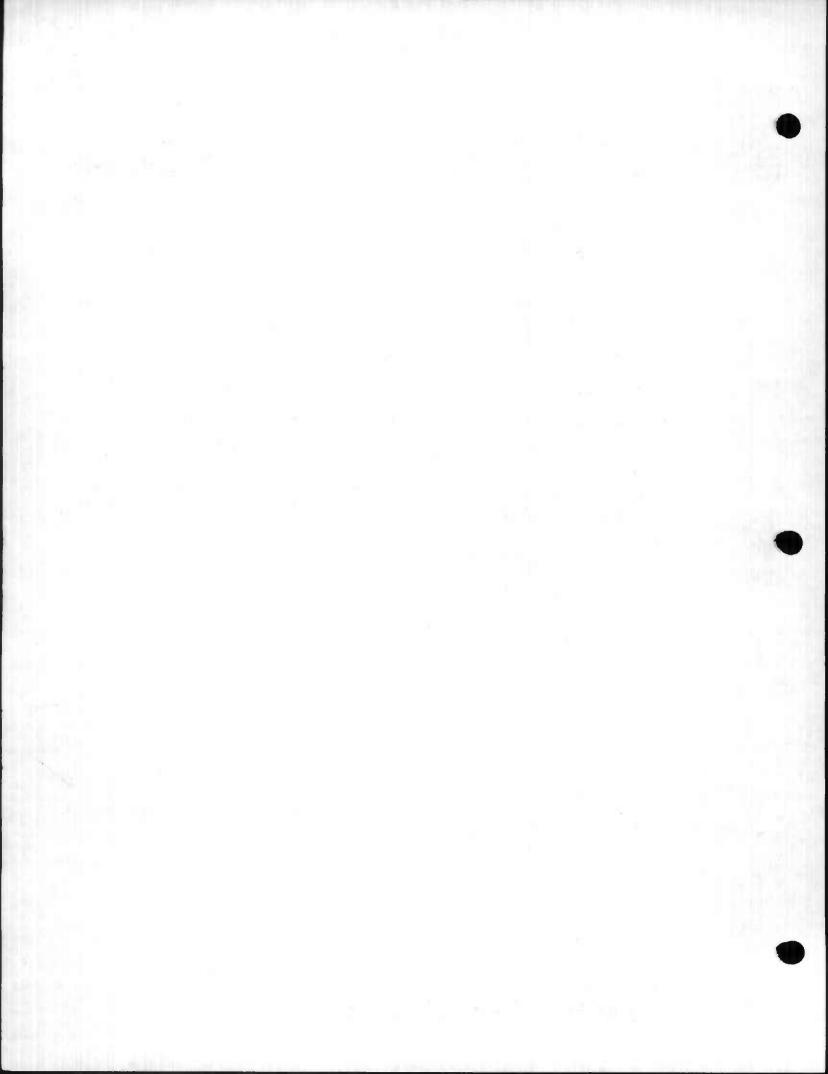




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State of Maryland / Department of Health and Mental Hygiene Q

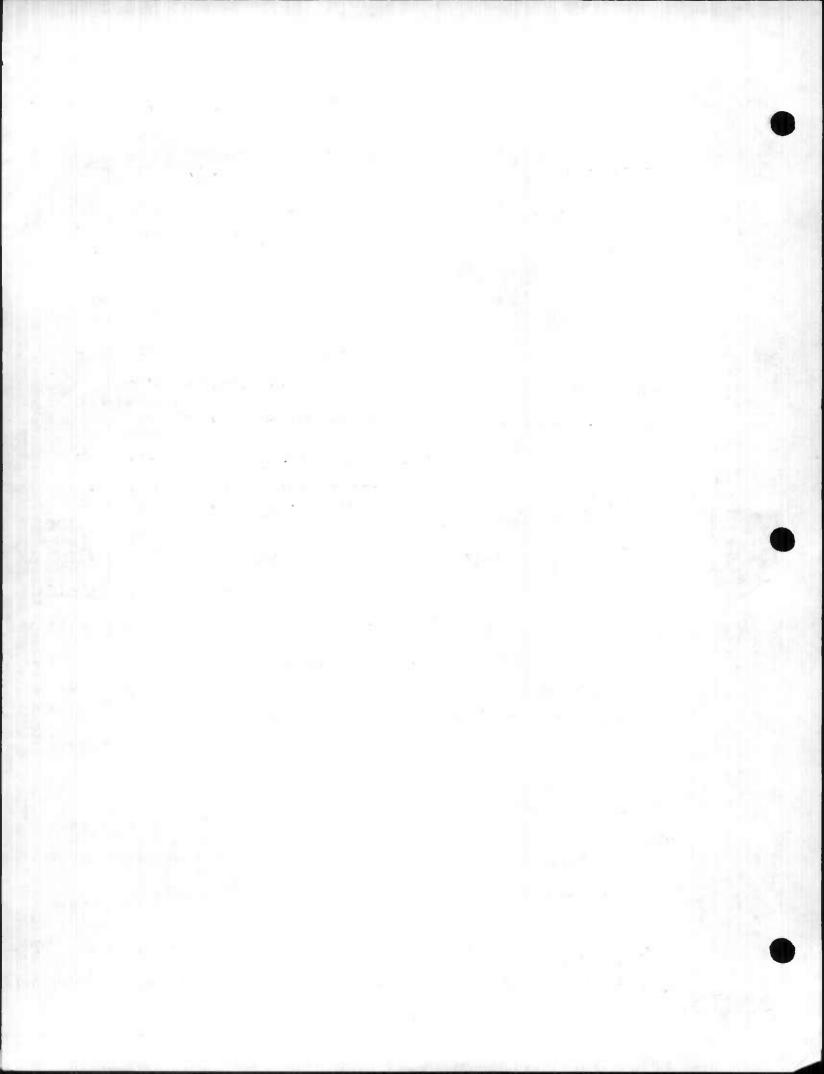
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iysiciar Medica	_	KATHARIN	E COLD	IKE					J	ANUARY		9	11:40 A	
camine	_	4a. Facility Nama (If not institution, giva street and number)						4b. City, Tov	vn, or Locat	tion of Death				
	4	GENESIS 5. Social Security Num					if Under 1	Year If Under 2	M blee	D 4 -4 D1 H			COUNTY	
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3		10a. Stata 1	0b. County		10c. C	City, Town or Le	ocation					1	IOd. Insida City L	
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Physicia: /Medica	-	Decedent's Name (First, Midd	Rose	Ma	ary M	ice1	i Cur	tis	Month Janua	Day	Year L999	3. Time of Death 2:00 PM	
Examine Funeral Director	er	4a Facility Neme (If not institution 219 Trappe Roots Social Security Number 218–30–7414			(In yrs. lest birtl		If Under 1 Yaa Wonths Days			rth ey, Year)	9. Birthpl	nore lace (State or Foreign try)	
and	-	Usual Residence of Decedent 10a. Stete 10b. Count	,		10c. City, Town	or Local	tion				10	0d. Inside City Limits	
a-f sh	io	Maryland B	altimore					Dundal	k			1 ☐ Yes 2 🛣 No	
th with the	Funeral Director	10e. Street and Number 219 Trappe Road 21222									of What Country? ced States		
LIS 8	2	11. Marital Status 1 Nevar Married 2 Ma 3 Widowed 4 Divorce	H Vas (Forcas? s 2.⊠No Giva		If Y	s Decedent of es, specify Cul	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yas or No Rican, etc.)		e - Amarica k, White, d		
iona. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 Years 16a. Decedent's Usual Occupation (Giva kind of work done during most of wo							king	16b. Kind of Bu	Esta		
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1 and 2 st Health end em 27 le m Ather traun		19a. Informant's Name/Relation Jeffrey G. C		1				Road Du					
20 2 2		20a. Method of Disposition 1 Burial 2 Cremetion 4 Donation 5 Other (n State		, cremet	tory or other pl	Corp. 1/	Date 23/99	20c. Location - TOWSON			
permit. Pagas 1 at Department of Hear Important: If item 3 any Injury or other once.		21. Signature of Funeral Service	W. Ko.	m + n	1/2 /	Dud 792	22 Wise	Funeral I	ndalk.	Marvland		222	
Physician /Medical		23a. Parti. Enter the disease shock, or heart failure. Lis	r complications that t only one cause or		()					errest,		Approximate Interval Between Onset and Death	
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that the deed by the eldetached for	/ Physician/Me	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part Congestive heart failure, emphysem						iven in Part I.	23b. Did tobacco use contribute to the cause		the cause of death?		
law requires that that as been signed by the 2 should be detached by the control of the control	Completed by								24e. Wa	s an autopsy ormed?	SV4	ere autopsy findings allable prior to mpletion of cause death?	
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or Attending situr death. Director: After d in by the fune	Certification:	2 Accident								28f. Location (Street end Number or Rural Route Number, City or Town, State)			
Hospi 24 hou Funer taly fill	edical C	29e. Certifier (Check only one) (Check only one)	Examiner: On the	ne best of basis of e	xaminetion and	deeth o	ccurred at the stigation, in my	ime, date and place opinion, deeth occur	, end due to the rred at the time	cause(s) and ma , date and place,	nner as si and due to	lated. the cause(s)	
To the virbing To the comple	Me	29b. Signature and fittle of certific	g. Euli	anh	и.	D .		7015		29d. Date signed Janua		Day, Year) 21, 1999	
6		30. Name and address of person Kathryn J.	Eubant	, I	Bayvie		int) Medic	al Cent	er, t	Baltimo	וצו,	Marylana	
State Registrai		31. Data filed (Month, Dey, Year	999 4	Registrar	s Signature		lower	_					

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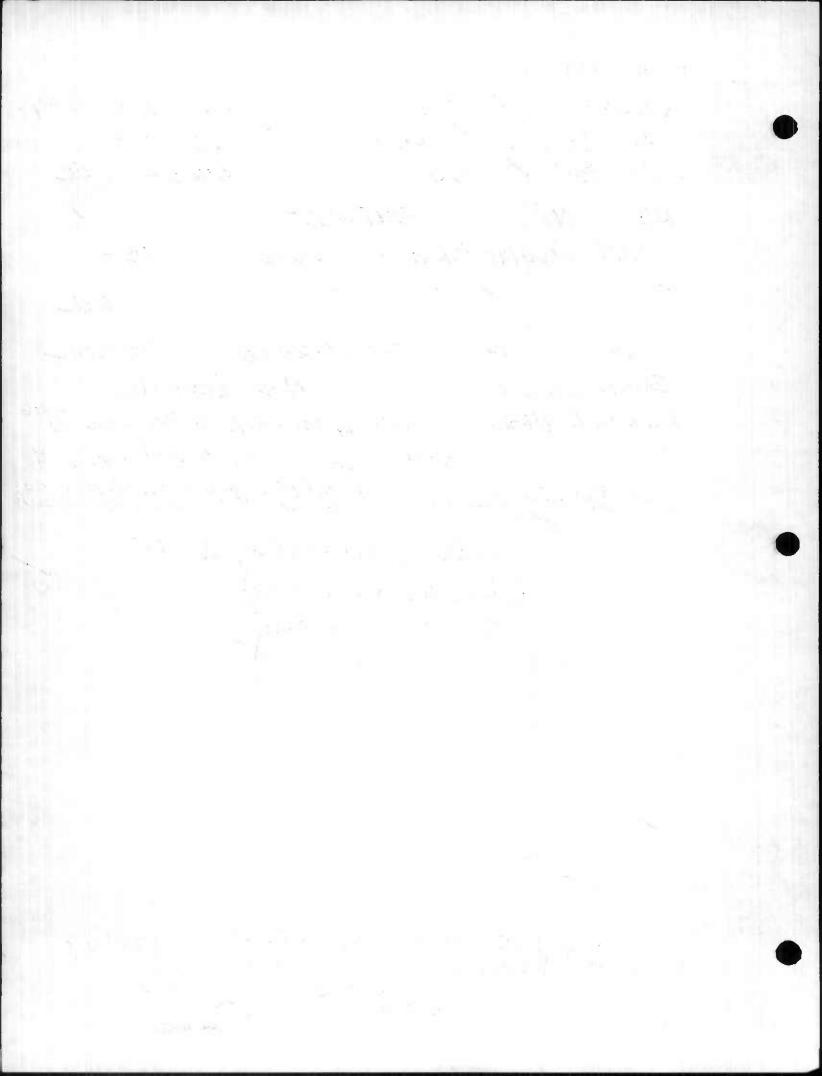
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 31per V.R 1/26/99 reb Certificate of Death Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** 12:50 pm /Medical 4e. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deat **Examiner** 5. Social Security Number and 6. Sex 2/5-28-33571 M 3/5 F **Funeral** Days Director Usual Residence of Decedent the Marylend 10e. State 10b. County 10d. Inside City Limits 28a-f ahow must be nothled at MD Funeral Director Yes 2 No 10e. Street and Number 10g. Citizen of Whet Country? 6 Items 23a death 11. Merital Status Race - American Indian, Black, White, etc. res 2 No s, Give evant, the Medical Examiner Pages 1 and 2 should be filed within 72 hours efter Never Married 2 Married 1 Yes 21215-0020 1 Yes 2 No 6 Specify: Completed by Black 3 Widowed 4 Divorced "natural", 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiena. marked other than Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Ia marked other any Injury or other traumatic evant Be COASEY 19a. Informent's Name/Relationship (Type, BALTIMORE, NO 20b. Place of Disposition 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 238. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heert failure. List only the cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) **Examiner** Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest The law requires that the death certificate be execu Box 68760, Physician/Medical P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Be Completed 24a. Wes an eutopsy performed? After this certificeta has been 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA filled in by the funeral 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural death. 1 Yes 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menner stated. Medical 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29d. Date signed (Month, Day, Year) 12 M nath (Hem 20a) (Type, Plint) OO

32. Registrar's Signature JAN 2 6

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month,/Day

Year



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Deeth 3. Time of Death **Physician** Melvin Custalow 9:40 AM Jan 20 /Medical 4a. Facility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SINAI HOSPITAL If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) 04/06/1913 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** Days 17 M 2 F Virginia 219-05-6924 85 **Vrs** Director Usuel Residence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits r 28a-f show MD N/A BALTIMORE Yes 2 No Director 10e. Street end Number 10f. Zlp Coda 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be a 3401 Fairview Avenue 21216 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces?

1 XYes 2 No 8 / 29 / 4 2 If Yes, Give Yaar or Dates: 1 0 / 1 / 4 5 14. Race - Amaricen Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black þ 3 ☐ Widowed 4 12 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Contee SAnd & filed within 12 should be filed within and Mental Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Cement Finisher Gravel 6th Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Unknown Unknown 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 st nent of Health and ant: if itam 27 is r Melvin L. Custalow, Jr. 3401 Fairview Avenue, B alto., MD 21216 other 20b. Plece of Disposition (Name of cematary, cramatory or other plece) 1 / 2 7 / 9 9 Dete 20e. Method of Disposition 20c. Location - City or Town, Stete important: If it any injury or c 1 ₺ Buriei 2 □ Cremetion 3 □ Removel from Steta Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility $LEROY O \cdot DYETT$ & SON FUNERAL HOME, 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 the deeth. Do not enter the mode of dving, such as cardiac or respiratory errest. Approximate Intervel Between Onset end Deeth **Physician** /Medical immediate Cause (Finel VENTRICULAR diseasa or condition rasulting in deeth) **Examiner** Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated marks) YEARS CORONARY ARTERY DISEASE Physician/Medicai thet initieted events resulting in deeth) Last US8 Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MERLITUS þ 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed page 2 210 No certificata Division of Vital or Attanding Physician: Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospifal: 1 ☐ inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28h Time of 28c. injury et Work? 28d. Describe how Injury occurred After 5 Pending Investigation Naturei 24 hours after death. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyefolan: To the best of my knowledge, death occurred et the time, dete end piace, and due to the cause(s) end menner es stated.

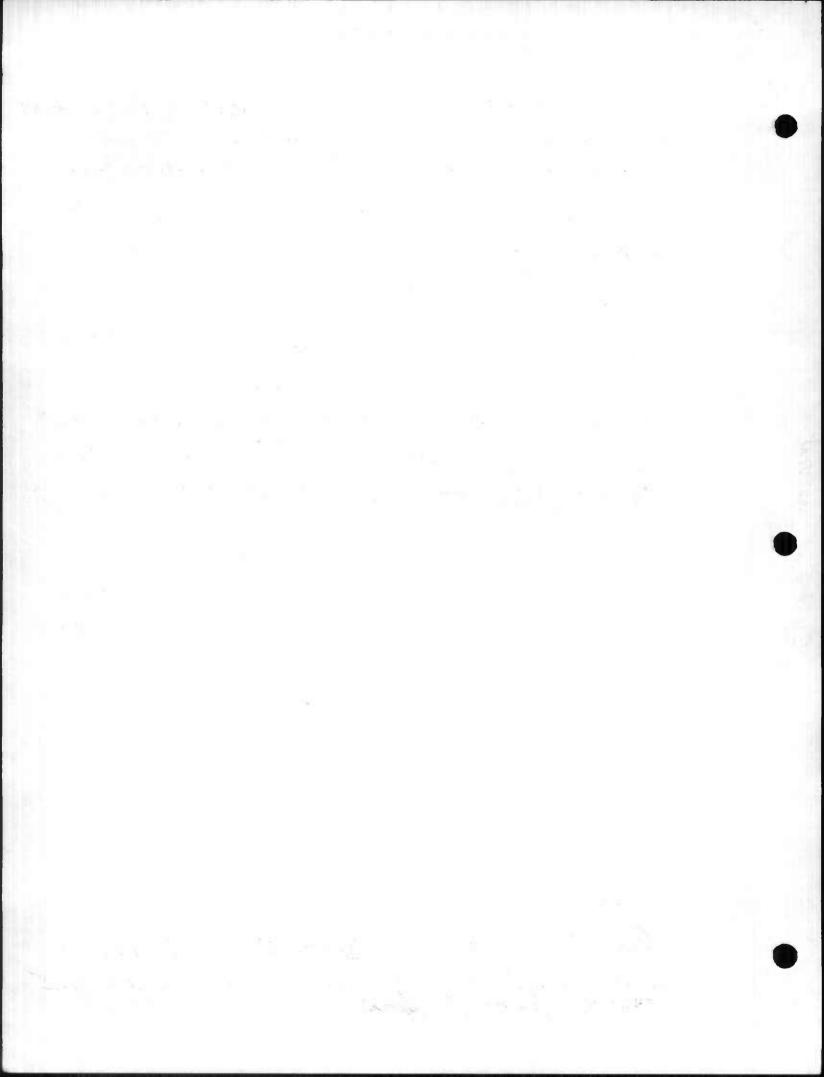
Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end manner steted. 29e. Certifier Medical (Check only one) Within 2 To the 29d. Data signed (Month, Day, Year) 0

e of deeth (item 23e) (Type, Print)

PARK HGTS AVE.

State Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Physician William January 25, 1999 12:00 PM Francis Carberry /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death c. County of Death Examiner Baltimore 7. Ago (th yrs. last birthday) H Under 1 KOSECIA P tranklin Square 8. Dete of Birth (Month, Day, Year)
June 12, 1926 If Under 1 Year 6. Sex 10 M 2□ F 5. Social Security Number Birthplece (State or Foreign Country) Months Days Hours Min. 204-16-5984 72 Pennsylvania Usual Residence of Decedent 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Baltimore Baltimore Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9553 Devonwood Court 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Detes: WW 11 Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Baltimore County 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Carberry Amelia Schaeffer 19e. Informant's Neme/Relationship (Type, Print) brother-19b. Meiting Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James Kirby Elliott 9553 Devonwood Ct., Baltimore, MD in-law) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from Stete Gardens of Faith 1/29/99 Baltimore. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee Schimunek Funeral Home, Inc. 23a. Part1. Enter the disease accomplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. Mayo T. Zavoyou MD 21236 Approximate Intervet Between Onset and Death Immediate Cause (Finel ·Arteriosclerotic Cardiovascular Disease disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Dilated Cardiomyopathy, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Was en autopsy performed? Diabetes Mellitus, Hypertension 2 X No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner?
1 Yes 2 No Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 27. Magner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 3 ☐ Suicide 6 Could not be Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

P.O. Box 68760, Records, Division of Vital or Attending Physician: To the Hospital or within 24 hours eft To the Funeral Di completely filled in

Funeral

Director

must be notified at

Department of Health and Mental Hygiena. Important: or Nems 23a or Important: If Nem 27 is marked other than "natural", or Nems 23a or any injury or other traumatic event, the Medical Examiner must be noted.

1 and 2 should be Health and Mental

Physician /Medical

Examiner

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Registrar DHMH 16 Rev 6/95

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After

hours efter death. Iuneral Director: After the filled in by the fur

31. Dete filed (Month, Dey, Year)

Julie Casani

JAN 26 1999

the Am. Chram

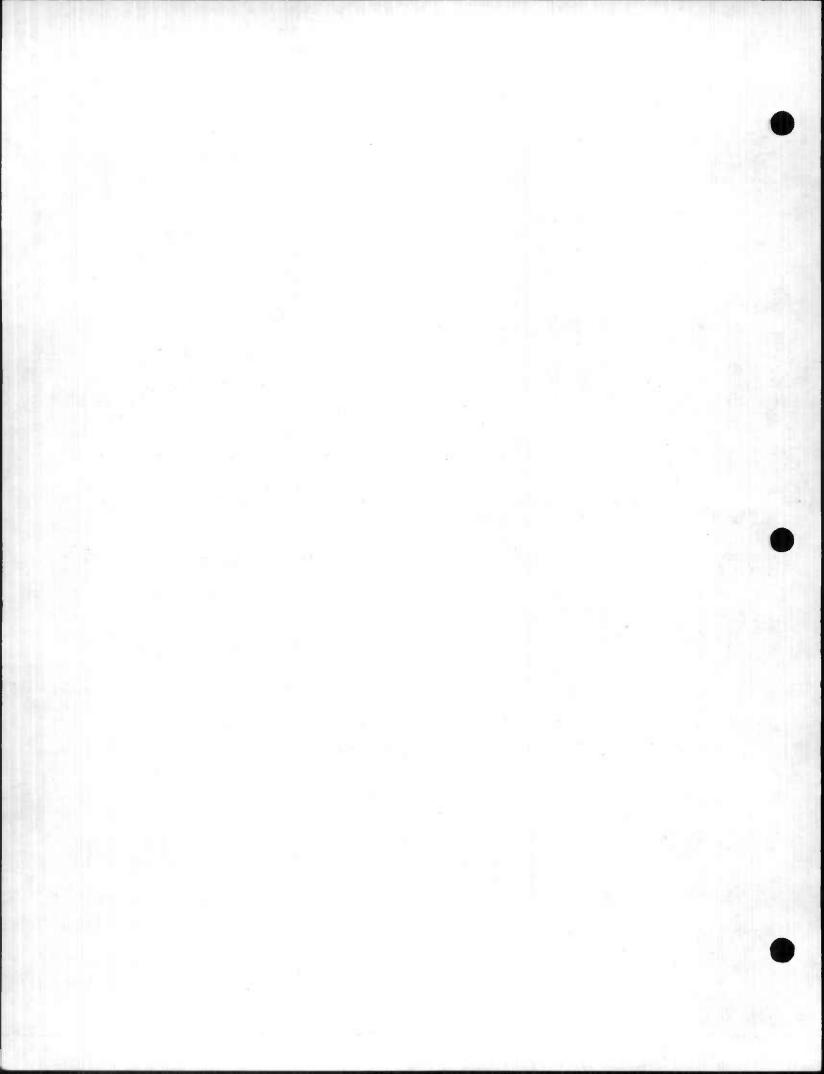
30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

Square Drive Baltimore, MD 21237

028214

January 25, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Marie Elizabeth Danna Month 4b. City, Town, or Location of Death 4c. Con 1999 6:05 P.M 4c. County of Death 4e Fecility Name (If not institution, give street end number) SPUARE BALTIMORE Hospila TRANKlin Ale 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) 6. Sex Birthplece (State or Foreign Country) Deys Hours 10M 20F Months 217-20-2383 88 June Maryland Usual Residence of Decedent 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 309 S. Taylor Avenue 21221 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien 11 Meritel Status Black, White, etc. 1 Yes 21 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify 3₺ Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) John Henry Duerbeck Rose Barbara Kaegel 19s. Informant's Name/Reletionship (Type, Print) Daughter | 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 S. Lorraine Ave. Essex, Maryland Rita A. Brawner 20b. Plece of Disposition (Neme of cemetery, cramatory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burlel 2 Crametion 3 Removel from Stete 4 Donation 5 Other (Specify) Sacred Ht. Of Jesus Cem. 1/27/99 Dundalk, Maryland 22. Name and Address of Facility Duda- Ruck Funeral Home of Dundalk, Inc. 21. Signeture of Funerel Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset end Deeth Immediate Cause (Final DAYS disease or condition resulting in death) EncephalopA Due to (or as e consequence of) ARRES Sequentielly list conditions, if any, leeding to immediate causa. Entar Undarlying Cause (Diseese or Injury that initiated avants resulting In death) Last Due to (or es a consequence of): Disease CORONARY ARIERY Due to (or es a consequence of) ongeslivE HEARI Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No

Physician /Medical Examiner

reportant: If item 27 is marked

Physician

/Medical

Examiner

10a State

Director

Funeral

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Be

Funeral

Director

28a-f

or Barns 23s or

altimore, Maryland 21215-0020

MARI

8 and Mental

> Examiner Physician/Medical Completed Be Medical Certification: To

spital or Attending Physician: hours after death. neral Director: After this certifica To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b.

P.O. Box 68760

Records,

Division of Vital

29e. Certifier (Check only one) 29b. Signeture and title of certifier

State Registrar

25. Was casa raferred to medical exeminer? 1 Yes 2 No

27. Mapner of Deeth

1 Netural 2 Accidant

3 Suicide

4 Homicide

5 Pending

JAN 2 6 1999

investigation 6 Could not be determined

IAbeles

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

28b. Time of

28a. Date of Injury (Month, Dey Year)

24b. Were eutopsy findings aveilable prior to 24a. Wes en eutopsy performed? completion of cause of death?

2 No 1 Yes 2 No 26. Placa of Death (Check only ona)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Describe how injury occurred 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated.

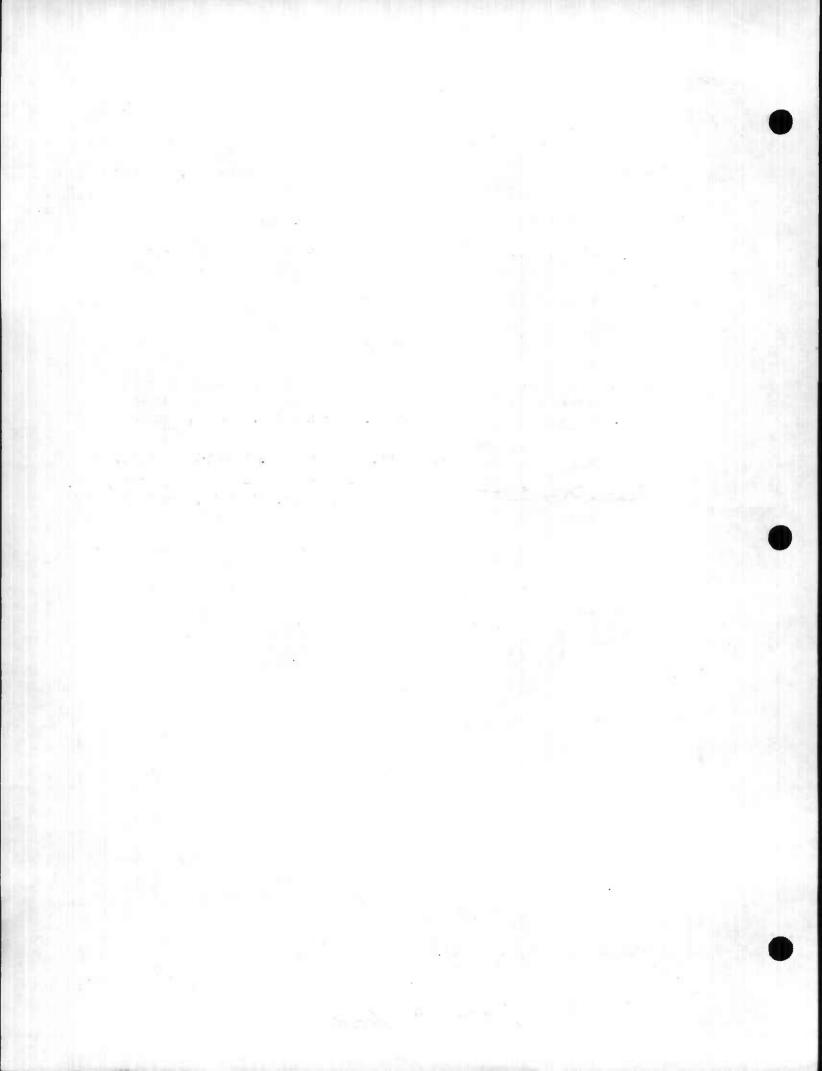
Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Nama and address of person who complated causa of death (Item 23a) (Type, Print) Shinners

9000 32. Registrer's Signeture

SQUAKE DR. BATTIMORE MARYLAND



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day RUTH ROBINSON DOYLE January 22, 1999 9:50 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 816 Fairway Drive Towson Baltimore County If Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country). Days Months Min. 1□M 2\ F Hours Aug 16, Maryland 215-03-8032 10b. County 10c. City. Town or Location 10d. Inside City Limits Towson 1 ☐ Yes 2 ♥ No Baltimore County Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21286 816 Fairway Drive USA 11. Marital Status 12. Wea Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown 12 th Tool & Die 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James Jackson Ferrens Alice Lavinia Ridgely 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3753 Proctor Lane, Baltimore, (Niece) Bonnie Hyle, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdns 1/27/99 Timonium, Maryland 21. Signature of Funegal Service 22. Name and Address of Fecility Masten D. awson Mitchell-Wiedefeld Home Lawson 6500 York Road, Baltimore, Maryland 21212 onler the mode of dying, such as Cardiac or respiretory errest, Approximate 23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each lime. Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed?

Physician /Medical Examiner

physician

for use as

signed by the e

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al or Attending Physician: The strar death.

I Director: After this cartificated in by the funeral director, pr

To the Hospital or within 24 hours at To the Funeral D

as the

Examinar

Physician/Medical

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Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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10s. State

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylen Department of Health and Mentel Hygiane.
Important: If them 27 is marked other than "natural", or flems 23s or 28s-f show with jujury or other traumstic event, the Medical Examinating the notified at page.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Division of VItal Records,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yas 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 22 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending tnjury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated. (Check only 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of 29d. Data signed (Month, Dey, Year)

30. Name and addre 7600 31. Date filed (Month, Day, Year)

DKIU 32. Registrar's Signature JAN 26 1999

TOWSON

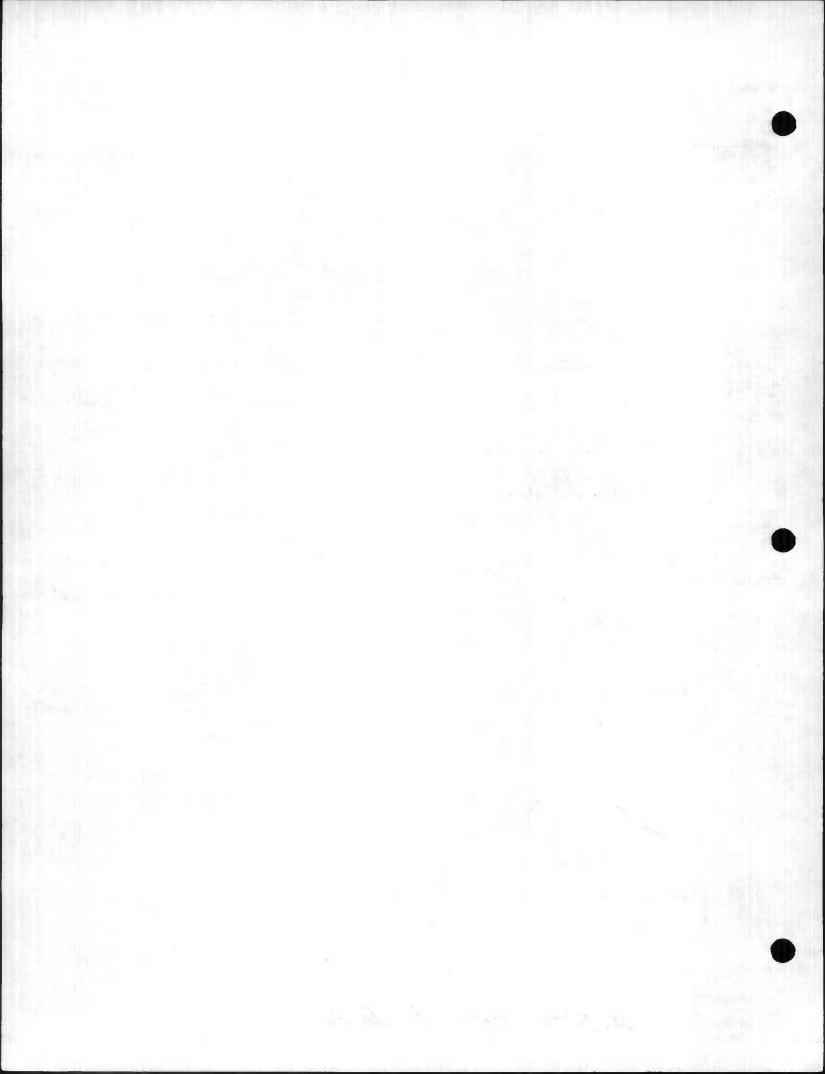
M

AYMAN F. AKKAD, M.D.

21204

99

uth Plann 23a) (Type, Print)



3. Time of Death

8:10 AM

9. Birthplace (State or Foreign Country) Va.

10d. Inside City Limits

1 Yes 2 No

21234

Approximate Interval Between Onset and Death

HOURS

YEARS

YEARS

DAYS

24b. Were autopsy findings available prior to completion of cause of death?

Baltimore

White

2. Date of Death

Day Year 24, 1999 JANUARY **Physician** JOHN VANDO DURRER /Medical 4a Fecility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 4 1917 5. Social Security Number **Funeral** Days 1 M 2 F Yrs. 223 18 7962 81 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or itama 23a or 28a-f show treumatic evant, the Medical Examinat must be notified at Directo Baltimore Baltimore Co. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9524 Burton Avenue 21234 permit. Pages 1 and 2 should be filed within 72 hours efter deeth begarment of Health and Mental Hydrene. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other treumatic event Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Beth. Steel Co. 12th Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fannie Drummonds William Durrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Van Durrer / 9524 Burton Ave Baltimore Md Son Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1/27 | Baltimore Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hartley Miller Funeral Home, CHTD. iller 7527 Harford Rd. Baltimore, 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or hear failure. List only one cause on each line. **Physician** RESPIRATORY FAILURE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE the death certificate be executed physician end the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): CORONARY ARTERY DISEASE Box 68760 Physician/Medical Due to (or as a consequenca of): 80 RENAL FAILURE use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. P.O. 23b. Did tobacco use contribute to the cause of death? signed by t d be detech CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, P

1 Yes 2 No 1 ☐ Yes 2 XNo 25. Wes case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

1. Decedent's Name (First, Middle, Last)

29c. License number Cun D31826 where

29d. Date signed (Month, Day, Year)

24a. Was an autopsy performed?

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD LINTHICUM, M.D., 7601 OSLER DR., TOWSON, MARYLAND

Completed

Be

2

Certification:

Medical

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this funeral

of or Attending effer death. Director: Aft

To the Hospital of within 24 hours of To the Funeral D

31. Date filed (Month, Day, Year)

JAN 2 6 1999

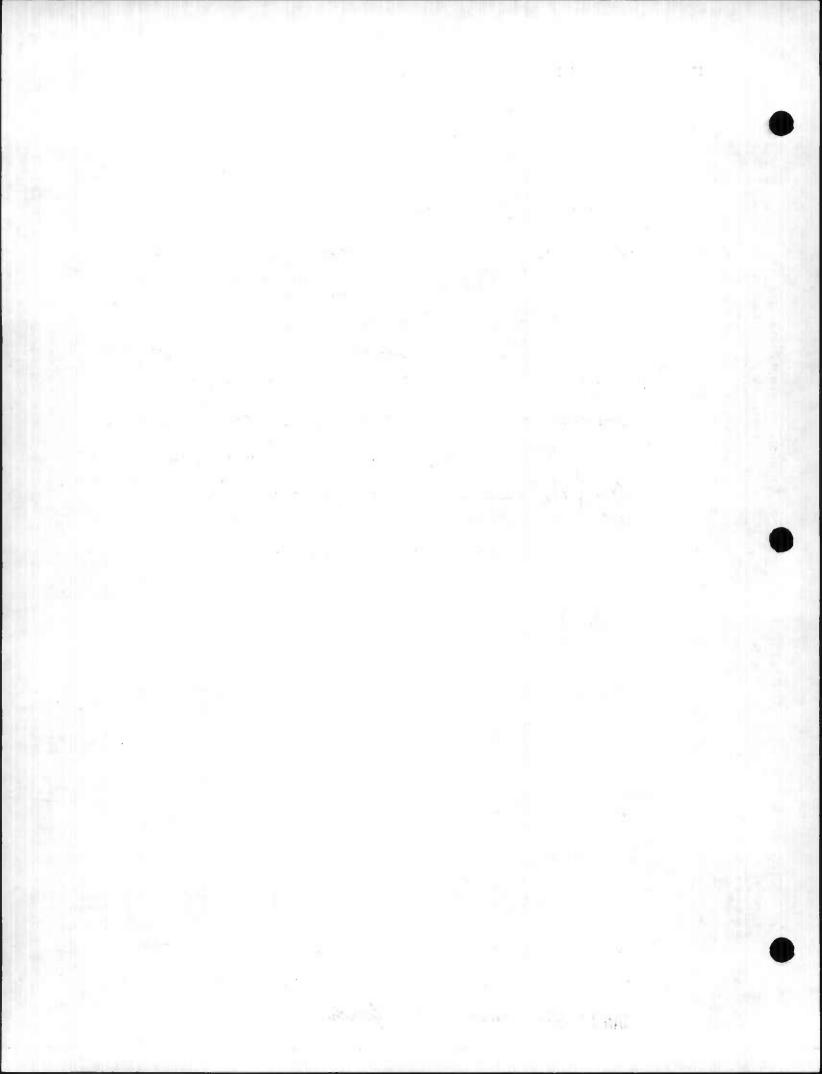
RESTRICTIVE LUNG DISEASE

32. Registrar's Signature

Sports

Registrar

I		PER PHYSICIAN Nama (First, Middla, Las		-99 WR	. Ce	rtifica	te of	Death	2. Data of D				3. Time of Death		
Physician		ANTONETT	A. De	ANGE	IIS				Month	Day CV 21		ear O	2:35pm		
/Medical Examiner	A AM	TOUTING TEES									County of I				
LAdminer		11 County G	eneral Ho	snit:	1			Westmins	ton						
Funeral	5. Social Sacu	urity Number 6. Se	1x 7. A		last birthday)	If Und	er 1 Year				Carrol		ce (State or Foreig		
Funeral Director	036-30	41	□ M 2 🖒 F		87 Yrs.	Months	Days	Hours Min	8. Data of B (Month, D NOV 2	, 191		R.I.	ce (Stata or Foreig		
land	10a. Stata	10b. County		10c. Ci	y, Town or Lo	ocation						100	10d. Inside City Limits		
or 28a-f ahomor notified at	MD											1 Yas 2 N			
the rest	10e. Street and Number 10f. Zip Code 10g. Citizen of W									izen of Wha	t Country	n			
th with 23a or	23 De	er Cross Ct	4 41 4			2	1136			1	JSA				
Jeath Tra 2	11. Marital Sta		12. Was Deceden		S. 13.				Specify Yes or N		14. Race	American	Indian,		
72 hours after death with the Maryland natural; or items 23e or 28e f abow ace I mart be notified at the by Funeral Director		Married 2 Merried		umed Forcas? If Yas, specify Cuban, Mexican, Pu yas, Giva 1 □ yes 2 ☑ No Specify:				rto Rican, etc.)		Specify	White, etc whit				
n 72 hours natural', deated by		15. Decedent's Edi	ucation		16a. Dece	dent's Us	ual Occur	pation		16b. K	ind of Busin				
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/Medical Examiner	Immediata Cause (Final disaasa or condition a. METASTATIC COLOW CARCINOMA									10	weeks				
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ificate be executed graysician and as the bunal-transit	Sequentially I	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause, Disease or injury c.													
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ttend deatl ttor: / the	2 Accid	te 6 Could not be						29f Location	28f. Location (Street and Number or Rural Routa Number, City or Town, State)						
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To the Hospita Within 24 hours To the Funeral completely filled	29a. Cartifier (Check on	1 Certifying Phy 2 Medical Exami	ner: On the basis	of axamina	wiedge, death	occurre vestigatio	det the tir	na, data and place pinion, death occ	e, and due to the	cause(s)	and menne f place, and	er es stat due to tr	ed. ne cause(s)		
thin 2 the parties of	one)		and mannar s	tated.					- Carrier Williams						
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19.11	30. Nama and	addrass of person who co	ompleted causa of	death (Iten	23a) (Type,	Print)				,					
	TH	omas Ga	aluin u	O	295 5	STO	165	Ave 1	NESMI	NSK	in m	D	21157		
State	31. Data filed	(Month, Dey, Year)	32. Regist	rar's Signa	tura ,	1									
Registrar		18N 9 6 1000			A.A.		400	•							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** 8:30 Virginia Marie Downey Tan 20 1999 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner St. Agnes Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 22, 1911 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign 1□ M 2ØF Deys Min 192 09 1647 87 Yrs. Pennsylvania Director Usual Residence of Decedent the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23a or 110 Club Road 21122 U.S. permit. Peges 1 and 2 should be filed within 72 hours effer death in Deportment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Merried 2 Married 1 X Yes 2 □ No If Yes, Give Yeer or Detes: W • W • II 1 ☐ Yes 2 2 No Specify: þ Specify: White 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Clerk Post Office 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Carmelo Lavieri Michael Tortorelli 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 8467 Church Road Barbara McLean / niece Pasadena, Maryland 21122 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20e. Method of Disposition 20c. Location - City or Town, Stete 1/26/99 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete San Diego, CA. Rosecrans National Cem. 4 □ Donetion 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 100 (one Pen1. Enter the Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. 23a. Pert1. Enter the Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical SEPSIS 4 BAYS Examiner Due to (or es e consequence of): Physician/Medical Examiner Preumonia Week Aspiration physician end the buriel-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es e consequence of) thet initieted events resulting in deeth) Last Due to (or es e consequenca of) 88 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? certificate has b lirector, page 2 sl 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 sins 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 5 Pending Investigation 1 Neturel 2 Accident 1 Yes 2 No ofter deatl Director: 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical (Check only one) within To the 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of cartifier Kaukoulle, MD 046704 20, 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ST AGNES HOSPITAL, BUT, MD MUTOMBO KANKONDE

Registrar

State

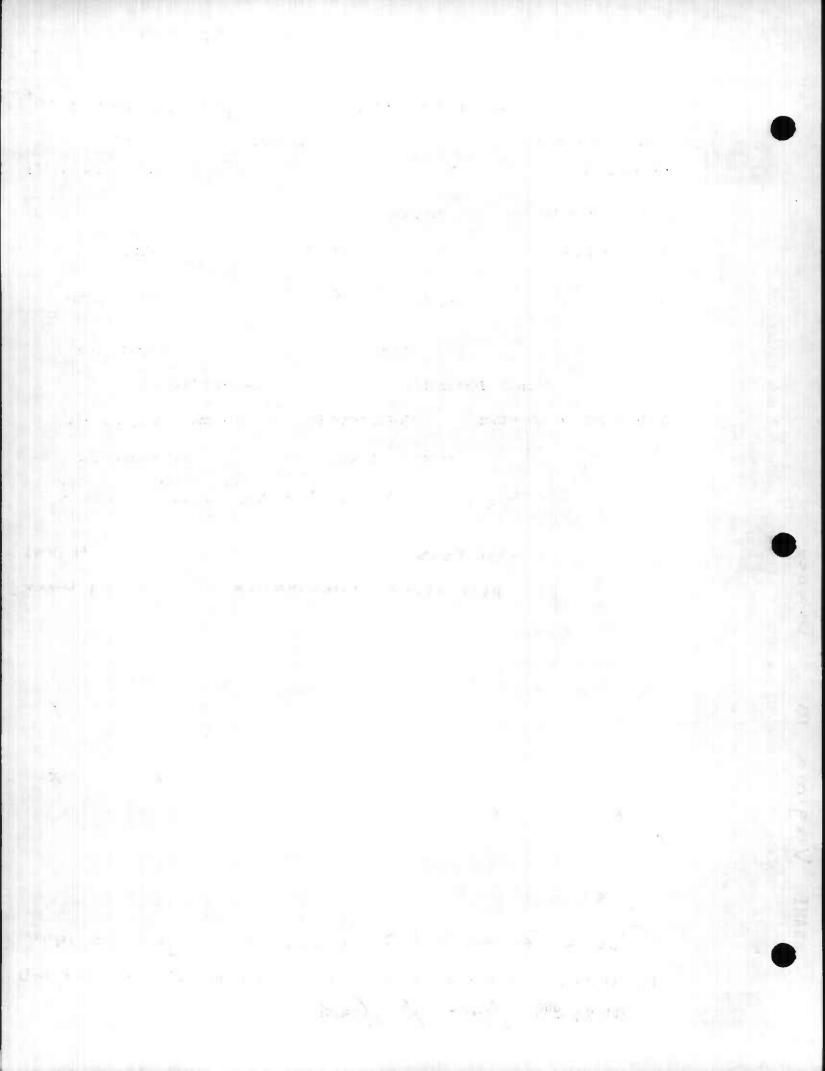
31. Dete filed (Month, Day, Year)

JAN 25

32. Registrer's Signeture

3

Virginia



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JAN Month 1999 22 1:50AM DANK BARBARA 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street and number) **HOWARD** 5822 STEVENS FOREST ROAD # 21 COLUMBIA 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) FEB 5, 1918 5. Social Security Number 9. Birthpiace (State or Foreign Days Hours 10 M 20 F MASSACHUSETTS Yrs. 011-14-9223 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Y Yes 2 No HOWARD COLUMBIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21045 U.S.A. FOREST ROAD # 21 5822 STEVENS 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: WHITE 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5 + Elementary/Secondary (0-12) FINANCIAL PLANNER SOCIAL WORK 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) HARRY ALLMAN FLORENCE **GORDON** 19e. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) HARRY DANK/SON 400 CEDAR STREET SOUTH HEMPSTEAD NY 11550 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT.PLEASANT CEMETERY JAN 24/99 HAWTHORNE NY. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS. INC. Tolato 8900 REISTERSTOWN ROAD PIKESVILLE 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Cause (Final disease or condition resulting in death) of Lung Stage Due to (or es e consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic garenic 24b. Were autopsy findings eveileble prior to 24a. Was an eutopsy Mitral value prolapse completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury et 28d. Describe how injury occurred 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner es stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier

attending physician and for usa as the buriel-transit The law requires that the death certificata be axecuted Records, P.O. Box 68760 ed by the a signed by t been has page 2 certificate Division of Vital or Attending Physician: this funeral After t To the Hospital or Attended:
Within 24 hours after death.
To the Funeral Director: Aft

Physician

/Medical

Examiner

Funeral

Director

28a-f show

MD

Direct

Funeral

à

Completed

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be incutived at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 29a enty injury or other traumatic event, the Medical Experimental PAGE.

Physician /Medical

Examiner

Physician/Medical Examiner

by

Completed

Be

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Certification:

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with the Manylend

State Registrar

DHMH 16 Rev 6/95

29b. Signature and title of certifier

Mirford, MD 11065 hittle Patoxent Parkway Columbia MD 32. Registrar's Signature

30. Name and/address of person who completed cause of death (Item 23e) (Type, Print)

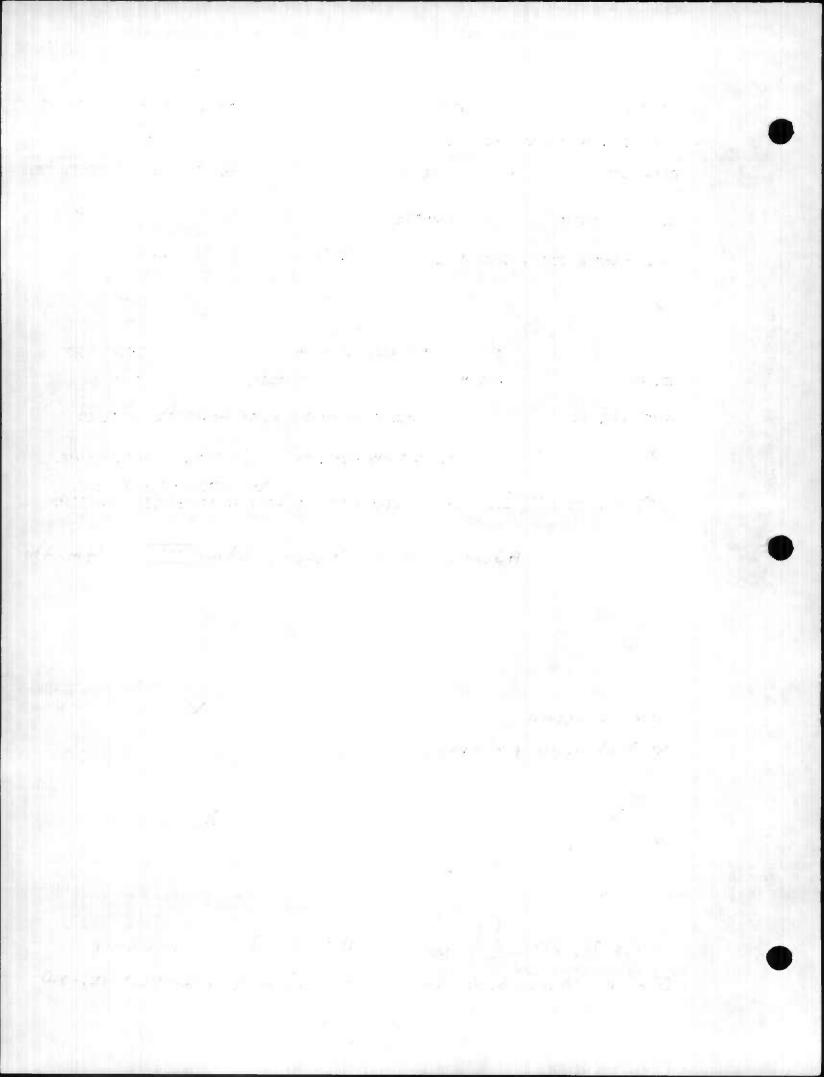
G. Spark

29c. License number 0305

29d. Dete signed (Month. Dav. Year)

2 6 1999 EED

MD



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 21 **Physician** 1850 JAMES ENGLISH /Medical 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY N/A THE JOHNS HOPKINS HOSPITAL If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Defe of Birth (Month, Day, Year) **Funeral** Months Deys 1**29**M 2□ F Hours 55 Yrs. 249-76-6822 Director DEC 17 1943 MARYLAND Usuei Residenca of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1XXes 2□No FALTIMORE CITY Directo MARYLAND N/A 258-71 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b Z a 23a 21230 2624 PIERPONT STREET U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Merital Status Black, White, etc. 72 hours after Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 12th grade FORKLIFT CPERATOR CONCRETE PRODUCTS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H ant: If them 27 is marked oth lury or other traumatic even Be JAMES ENGLISH SR MARY ENGLISH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2624 Pierpont St., Baltimere, Maryland 21230

20b. Plece of Disposition (Neme of cometery, cremetory or other plece)

Date 20c. Location - City or Town, Stete Beverly English/Wife 20e. Method of Disposition Burial 2 Cremetion 3 Removel from Stete Department of Important: If any injury or ance. 4 □ Donetion 5 □ Other (Specify) 1-29-99 EALTIMORE, MARYLAND MT. ZION CEMETERY 21. Signature of Fungral Service Lightee 22. Name and Address of Facility WILLIAM COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsef and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical ARRYTHMIA 2WKS Examiner Due to (or as a consequenca of): Physician/Medical Examiner 2WKS ISCHEMIC COLON The lew requires that the deeth certificate be executed physician and the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Due to (or es e consequenca of): US0 85 signed by the e P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown STATUS POST ABDOMINAL AORTIC ANEURYSM Records, þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed REPAIR 1 ☐ Yes 🏖 No 1 Yes 2 XNo of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending Investigation s after deeth. 1 Yes 2 No 2 Accident the 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E Hospital TO Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier completely (Check only one) 29b. Signeture and fittle of carming 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

BALTIMORE MD 21287

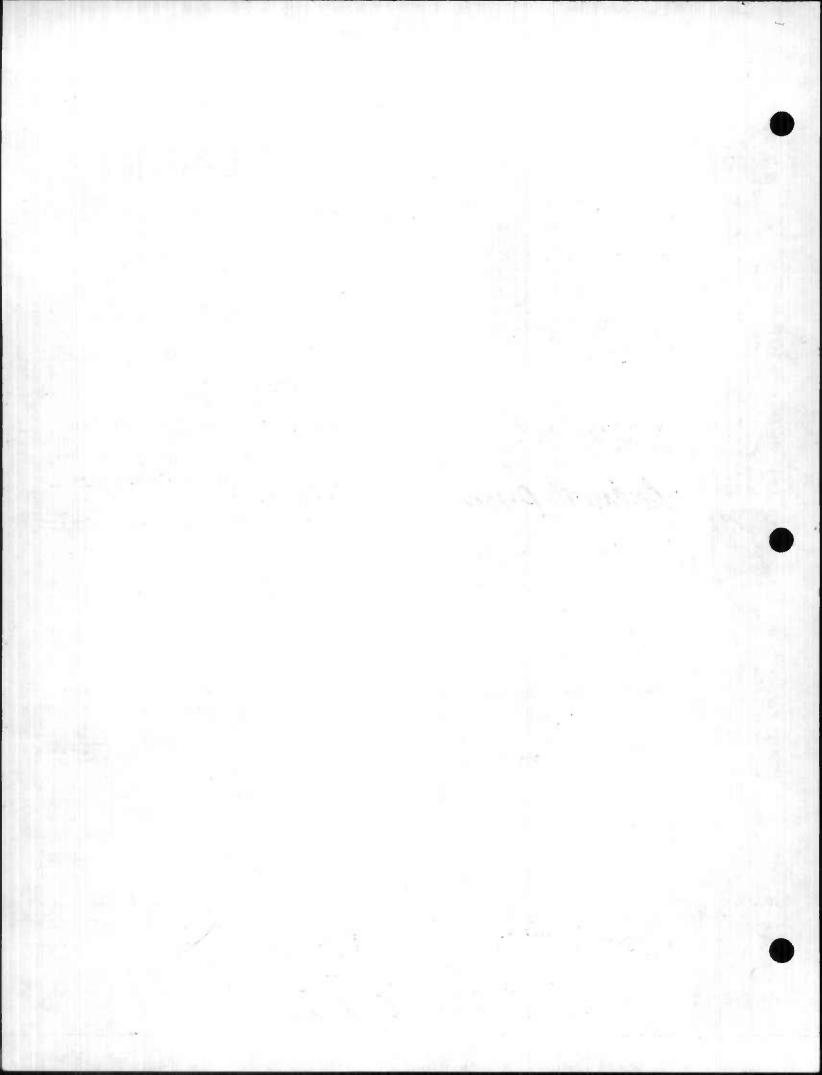
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

6 2

MICHAEL P GRANT MD

31. Dete filed (Month, Day Y

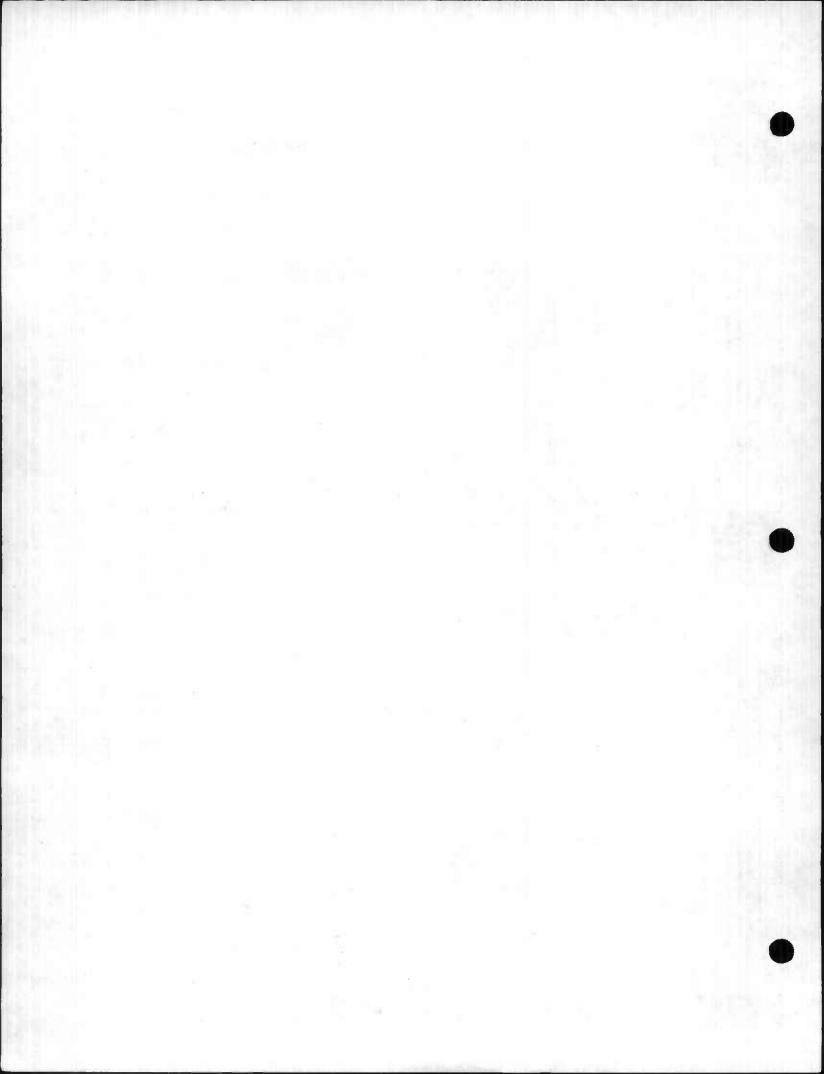
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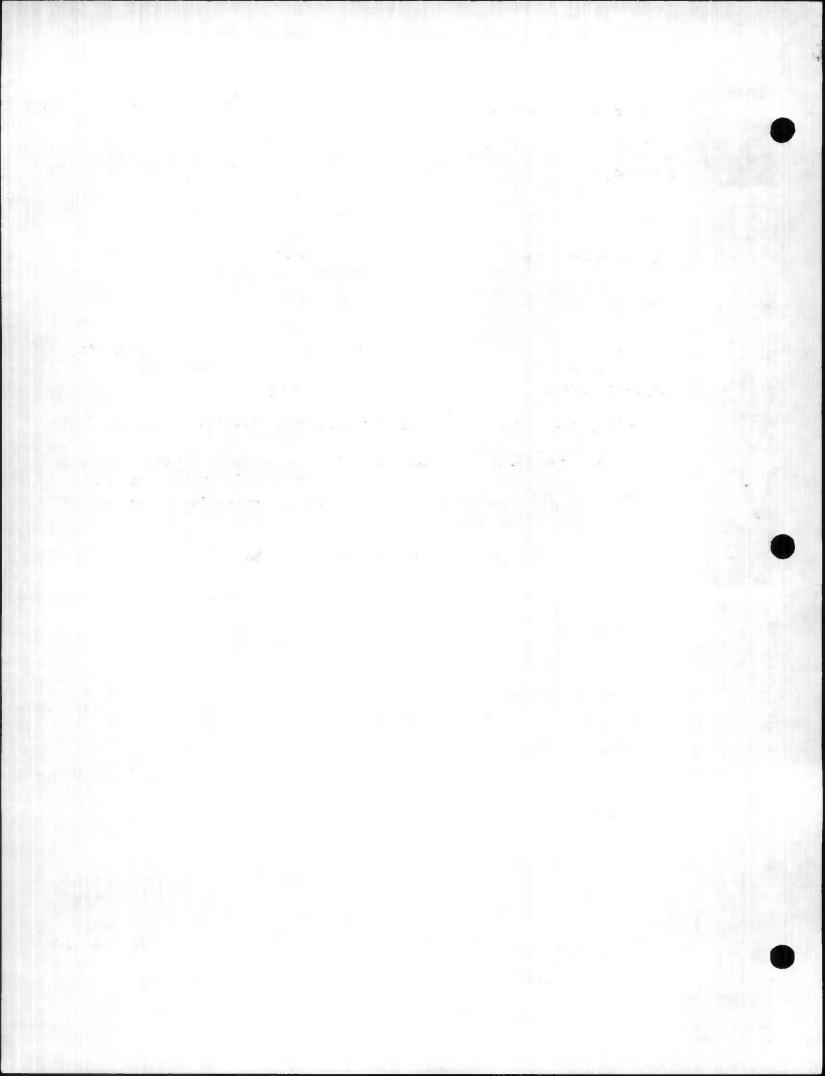
State of Maryland / Department of Health and Mental Hygiene

				Certificate	of Death	R	eg. No.						
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Funeral Director	5. Social Security Number 414–32–6146	6. Sex 1 □ M 2 ☒ F	nge (In yrs. last bin 73	Months [Year If Under 24 Hrs	8. Date of Birth (Month, Day,	Year) 1925	9. Birthplac Country Kentu	ce (State or Foreign) CKY				
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\$ 0 A	10e. Street and Number 1468 Snug Harl	oor Road	124			1	0g. Citizen of W	Vhat Country	?				
urs after	3QWidowed 4 □ Divorce	If Yes Give	:?] No			Specify Yes or No- rto Rican, etc.)	Blac	- American k, White, etc : Whit					
72 hours	15. Decede	nt's Education est grade completed)	16a.	Decedent's Usual (Occupation done during most of wo		16b. Kind of Bu	usiness/Industry					
dithin 121	15. Decede (Specify only high Elementary/Secondary (0-12)	T		life. DO NOT use	retired)		Own Ho	ome					
be file		, Last)		146	18. Mother's Na	me (First, Middle, I							
Vial Wents M	John Franklin	Sneed		January 24 19 4b. City, Town, or Location of Death 4c. County of Anne A. West and J. City. Town or Location bady Side 10t. Zp Code 20764 USA 20764 US					22 or Town, State MD				
Maryland 2. d 2 should be filed w d 2 should be filed w th and Mental Hygie 7 is marked other ti traumatic event, ti	19a. Informant's Name/Relation	ship (Type, Print)	19b	Meiling Address (S	itreet and Number or F	lural Route Number	Baltimore, MD 21222						
of Lead of Lea	Patricia Peri	y - Daughte		143 Del H	aven Road,	Baltimor	e, MD 2	1222					
Baltimore, semit. Pages 1 as appartment of Hea mportant: If Nam: may Injury or other and.	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 Removel from Stat	cemeter	y, crematory or other	er plece)	Date	20c. Location -	City or Town	, State				
timen Partition Jury	4 Donation 5 Other (01/27	/27 Brooklyn, MD									
Baitimo pemit. Pagei Department of Important: If I any Injury or once.	21. Signature of Euneral Service	Picensey An	111			Home, P.	Α.						
	23a, Part1. Enter the disease.	complications that cause	ed the death. Do r	12 Rid	gely Avenu	e, Annapo	lis, M	2140	1 pproximate				
Physician /Medical	Immediate Cause (Final	t only one cause on each	line.					i o	iterval Between inset and Deeth				
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f Vital Re- yelden: The iev secrificate hes director, page 2						1□ Ye	s 2 No	10)					
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hysick hysick nis cer il direc	examiner?	Hospital:	tient 2 ER/Ou	tpatient 3 DOA	Othor			er (Specify)					
Attending Physicien: rideath. ector: After this certific by the funeral director.		28a. Dete of In (Month, D		ime of 28c	Injury at Work? 28d. Describe how Injury occurred								
DIVISION C transfer death. at Director: After ted in by the funer	3 Suicide 8 Could 4 Homicide deten	mined 288. Place of I	njury - At home, fa etc. (Specify)	rm, street, factory, o	ffice			er or Rural F	loute Number,				
Division of Tothe Hospital or Attending Physical William 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		ng Physician: To the besi Examiner: On the besis and manner:	of examination and	, death occurred at Vor investigation, in	the time, date and place my opinion, death occ	e, end due to the courred at the time, d	ause(s) and ma ate and place, a	nner as state and due to th	ed. e cause(s)				
of the complete of the complet	29b. Signature and title of certifi			29c. L	icense number	2	9d. Date signed	d (Month, Da	y, Year)				
	> Attar	D-38754 01-25-99											
36	30. Name and address of person		death (Item 23a) (Type, Print) 04. B	ASTERN	BLVI), M	D - :	21221				
State Registrar	31. Date filed (Month, Day, Year JAN	2 6 1999 D	Signature		back								



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-	Funeral	5. Social Security Num			Age (In yrs. le	est birthday)	If Under 1 Year	If Under 24 H		. Vana	e (State or Foreign				
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	yland	10a. Stata 10b. County 10c. City, Town or Location									10d	I. Inside City Limita			
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	23e or 24 ust be no	Md N/A Baltimore 106. Street and Number 107. Zip Code 107. Zip Code 108. Street and Number 108. Street and Number 109. Zip Code 109. Zip C										17			
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any	s should and Men is marke aumatic	19a. Informant's Nam		pe, Print)		19b. Mailin	g Address (Stree		Rural Route Numbe	r, City or Town,	Stete, Zip C	ode)			
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Baltimore	of He of Herr f fterr	20a. Method of Dispos		lemovel from St	CO		sition (Neme of netory or other pl	ece)	Date	20c. Location -	City or Town	n, State			
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Ball	permit. Page Department of Importent: If eny Injury or ence.	21. Signature of Fune	ral Service Licens	00		22	. Name and Addr	ress of Facility	Caple Fun	eral Se	rvice				
	00200	1) Ba	为	Con		5	502 Winn	er Aven	ue Baltim	ore, Mar	Maryland 21215				
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Division	tal or Attending Physician: Is after dealh: Is	2 Accident 3 Suicide	Investigation 6 Could not be	29e Place o	(Injuny - At hor	me farm str		Yes 2 No	28f Location /5	29f Location /Street and Number or Dural Pouts Number					
Di	after Directifi ertif	4 Homicide	determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity)					28f. Location (Street end Number or Rural Route Number, City or Town, Stete)						
	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp				is of examinetle				ace, end due to the occurred at the time,						
	within To the compl	29b. Signature and titl	e of certifier					29c. License number 29d. Date signed (Month, Day, Yo							
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	10	30. Neme and eddress	of person who co	ompleted cause	of deeth (Item	23a) (Type, U MEN	Print) 9. 14057	201 E- U	UNIV-PKH	JY, BA	LTIMO	RE, MD			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bayary 23: 1999 1:54 pm Willard George Fisher

4a Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death . County of Death 5. Social Security Number Baltimore ente square Hospital If Under 1 Yea 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) Days Months Hours 1 M 2 F 216-01-5794 90 June 8, 1908 Maryland Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits 1□Yes 2□No MD Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 Marion Avenue 21236 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married specify White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk/Fitting Balto, Gas & Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Duncan Fisher Cynthia Mary Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Helen V. Fisher 203 Marion Avenue Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Faith Cemetery 1/27/99 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Neme and Address of Facility Dippel Funeral Home Inc. 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximately a shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Infarction KNEHMONIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29c. License number 29d. Dale signed (Month, Day, Year) 29b. Signeture end title of certifier

Physician Box 68760. P.O. Division of Vital Records. To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral

Physician

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Examiner

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ortant: If Item 27 is marked other than "natural", or heme 23a or 28a-f show injury or other treumatic event, the Medical Examinar must be notified at

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Department of Health and Mental Hygiene.
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State Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ruttarris

32. Registrar's Signature

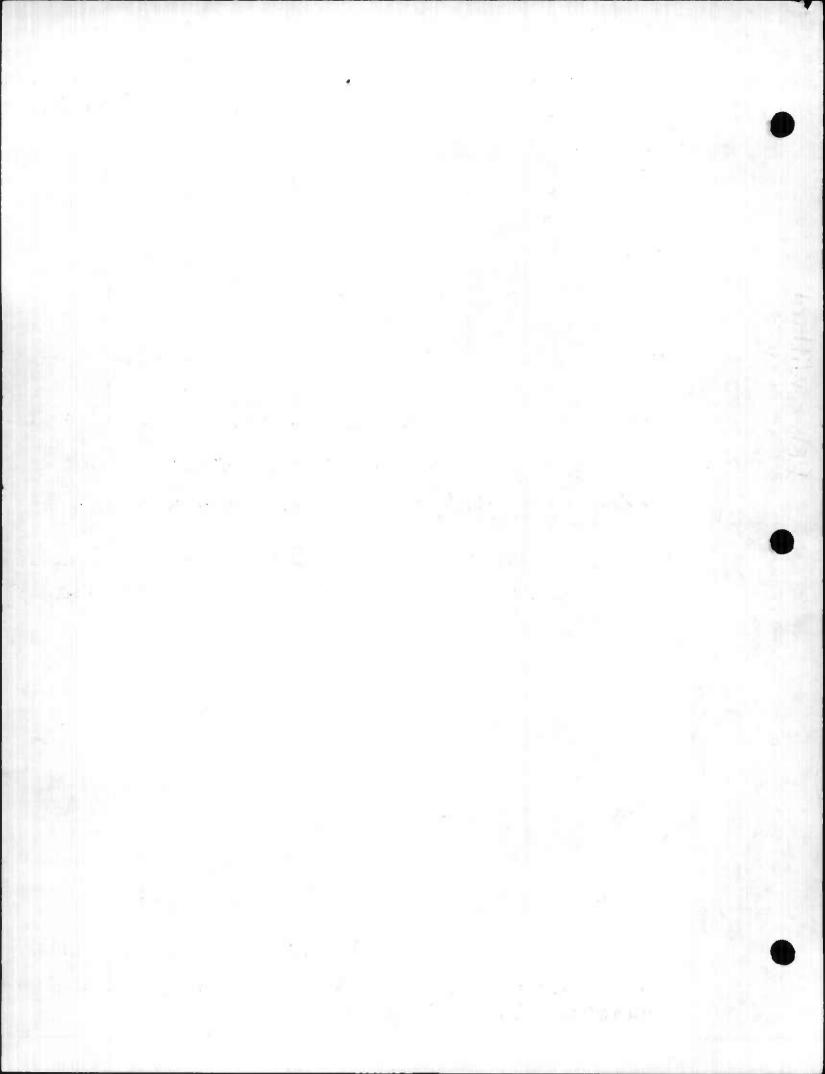
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31. Date filed (Month, Day, Year)
JAN 2 6 1999

01105

, 9000 Franklin Square Drive, Baltimore, MD 21237

January 23, 1999



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Stace 21, 1999 11:45PM January 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva streat and number) Baltimore City N/A Johns Hopkins Bayview Geriatic Ctr. if Under 1 Year | If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 1 M 2 F Sept. 12,1931 67 187-24-4732 Pennsylvania Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Dundalk Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 21222 8205 Bear Creek Drive 12. Was Decedent Ever in U.S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Giva 1 Never Married 2 Married 1 Yes 2 StNo Specify: Specify. 3 □ Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 9 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dorothy Kauffman Charles Rager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 722 Gregwood Ct. Lester R. Felix, Jr. / Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Gardens of Faith Cem. 1/25/1999 Rossville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. First Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one can be on each line. Approximate Interval Between Onsat and Death Immediate Cause (Final disaase or condition resulting in deeth) Due to (or as e consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last sebacions cust Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Amemia 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28e. Date of Injury (Month, Day Year) 28b. Time of Natural 2 Accident

Physician /Medical Examiner

Physician

/Medical

Examiner

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Examiner Physician/Medical

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Certification:

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3 Suicide

29a. Certifier

4 Homlcide

29b. Signature and titla of certifia

P.O. Box 68760, Division of Vital Records, or Attending Physician: After death. eral Director: A To the Hospital of within 24 hours of To the Funeral D completely filled in

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.

> 29c. Licansa number D0051156

1 ☐ Yes 2 ☐ No

29d. Data signed (Month, Day, Year) 99

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Johns Hopkins Cerrotrics Center

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

5 Pending

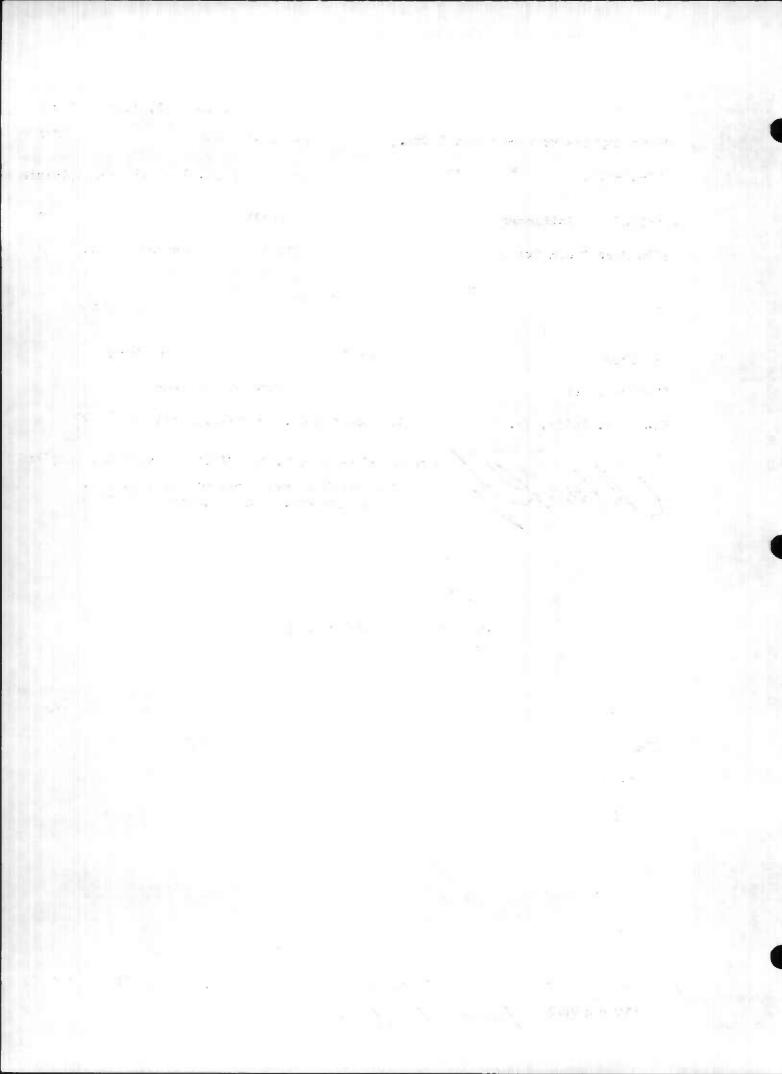
Investigation

6 Could not be determined

FANA V. CAPLAN W. O 31. Date filed (Month, Day, Year) JAN 2 6 1999 5305 BAYVIEWCIRCLE

32. Registrar's Signature

28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death SR. FINLEY JOSEPH 12.57 am. JANUARY 1999 21st 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) Days Months Hours 215 12 9153 1MM 2□ F Yrs. 76 Feb. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f Zin Code 10a. Citizen of What Country? 3803 - 8th Street 21225 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1X Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Detes: W.W. II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Anne Arundel Co. Insp. **Plumber** 11th 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Joseph L. Finley Estelle Jones 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Finley wife 3803 - 8th Street Baltimore, Maryland 21225 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1/25/99 Crownsville, Maryland Md. State Veteran Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the diseashock, or heart failure one e, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) SEPTICEMIA 18 HOURS Due to (or es a consequence of): NEUTROPENIA Due to (or es a consequence of): Sequentially list conditions

Physician /Medical Examiner

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The law requires that the death certificate be executed

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24 hours after deat Funeral Director: filled in by

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Division of Vital Records, P.O. Box 68760,

Physician

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Pages 1 and 2 should be filled within 72 hours after minimum of Health and Mental hygiens.

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Baltimore, Maryland 21215-0020

Director

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Medical Certification: To Be Completed by Physician/Medical Examiner

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	0.	TIC TRANS		CINOMA OF BLAP	PER 1 YEAR			
Part II. Other significant conditions of	ontributing to death but not real			23b. Did tobacco uss co	ontribute to the cause of death			
				24a. Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
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examiner?	Hospitel: 1 Inpatient 2	ER/Outpatient 3	Other	Home 5 ☐ Residence 6 ☐ Oth	her (Specify)			
27. Manner of Death Neturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred			
3 Suicide 6 Could not be determined	28e. Pleca of Injury - At h building, etc. (Speci	ome, farm, street, fect	28f. Location (Street and Number City or Town, State)	18f. Location (Street and Number or Rural Route Number, City or Town, State)				
				e, and due to the cause(s) end murred at the time, date and placa,				

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)

29b. Signature and title of certifier

Undin

PR. WIN MIN THU; HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST. BALTIMORE-21225 32. Registrar's Signature

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

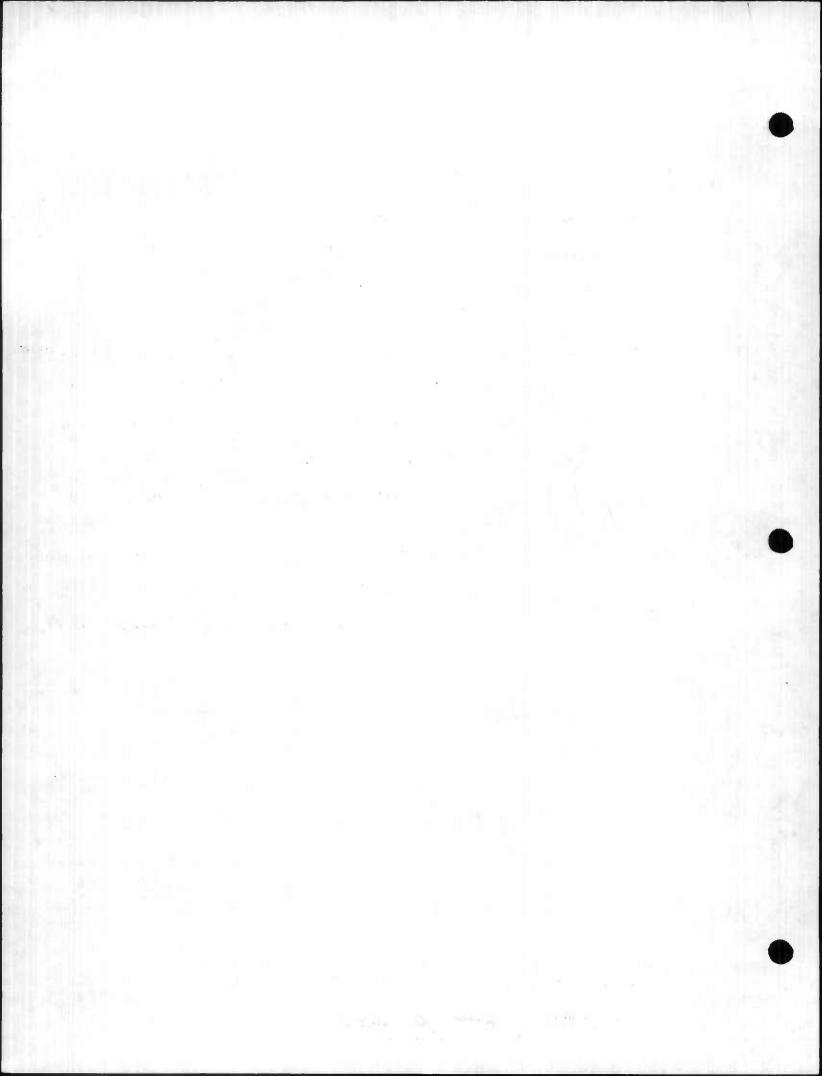
29c. License number

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29d. Date signed (Month, Day, Year)

JANUARY

21ST 1999.



Physician /Medical Examiner

The law requires that the death certificate be executed

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29a. Certifier

Box 68760,

Division of Vital Records, P.O.

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Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medicai

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

25. Was case referred to medical 1 Yes 2 No 27. Menner of Deeth 1 Neturet

2 Accident 3 Sulcide 4 Homicide

6 Could not be determined

28e. Placa of Injury - Af home, farm, street, fectory, offica building, etc. (Specify)

15 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the cause(s) end manner steted. (Check only one) 29b. Signatury and title

29c. License number 4

29d. Date sigp6d (Month, Day, Year)

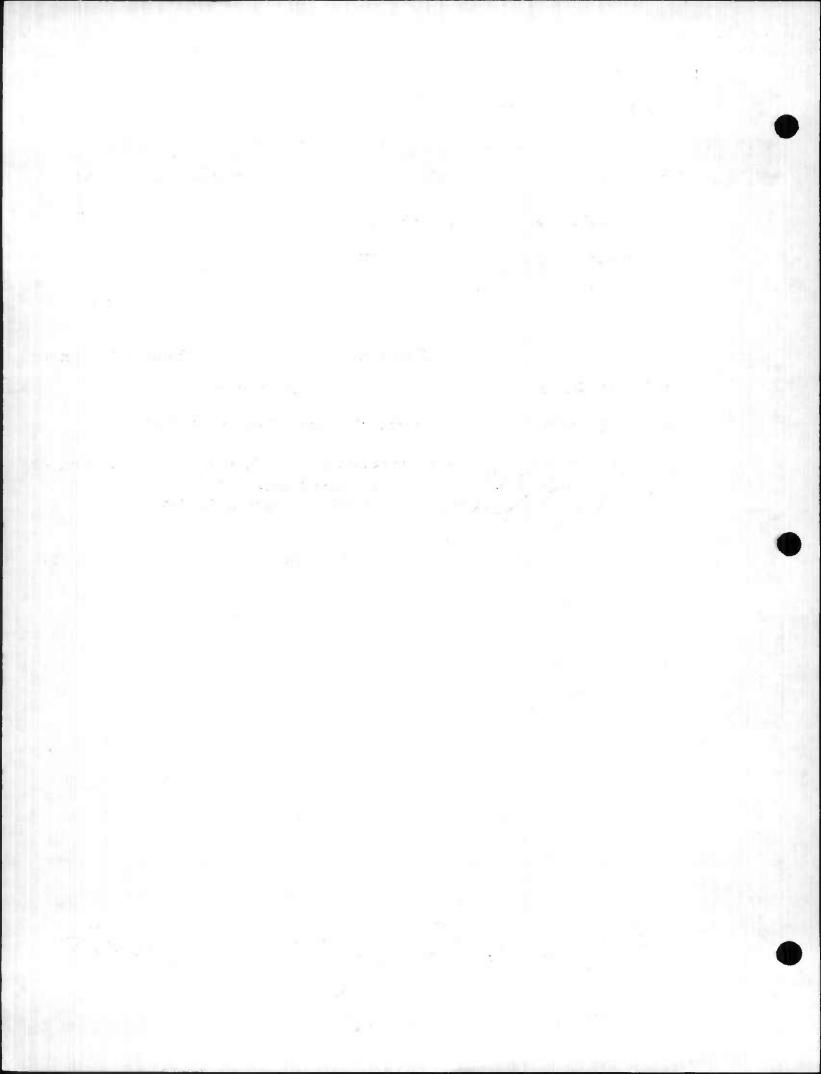
of deeth (Item 23e) (Type, Print) 30. Name and address of partian who completed cause

Ste phen 31. Dete filed (Month, Dey, Year)

11116 32. Regional's Signeture

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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death GREEN Month **Physician** 1741 24 1999 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number, Examiner University of maryland Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) if Under 1 Yeer 5. Social Security Number 6. Sex (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 223206780 1 M 2 F Months Deys 75 Yrs. Director 23 NORTH CAFOLINA Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f shore Examiner inset to receive at Yes 2 No Director MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4217 WOODMERE AVENUE 21215 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZONO If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on and of Health and Mental Hygiona. In the firm of the most 2 is marked other than "natural", or the ury or other traumatic event, the Medical English ury or other traumatic event, the Medical English 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK by ₩Vidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE PRJ VATE 3rd grade 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) JESSJE VINCENT VIOLA BRADLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informant's Name/Reletionship (Type, Print) Annie M. Williams/Daughter 4217 Woodmere Avenue, Baltimore, Maryland 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Rurial 2 ☐ Cremetion 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 1-29-99 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 21. Signature of Funeral Service Licen-22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W. NORTH AVENUE 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) congestive heart failure 24 hours Examiner Examiner that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequenca of): Part II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 Yes 2 No Hypertension þ The law requires 24b. Were eutopsy findings available prior to s peed s 24a. Was an autopsy performed? Completed Diabetes completion of cause of death? certificate has b Peptic ulcer disease 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2No 10 this funeral 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Director: / 6 Could not be 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hou.
The Funeral Direction 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.

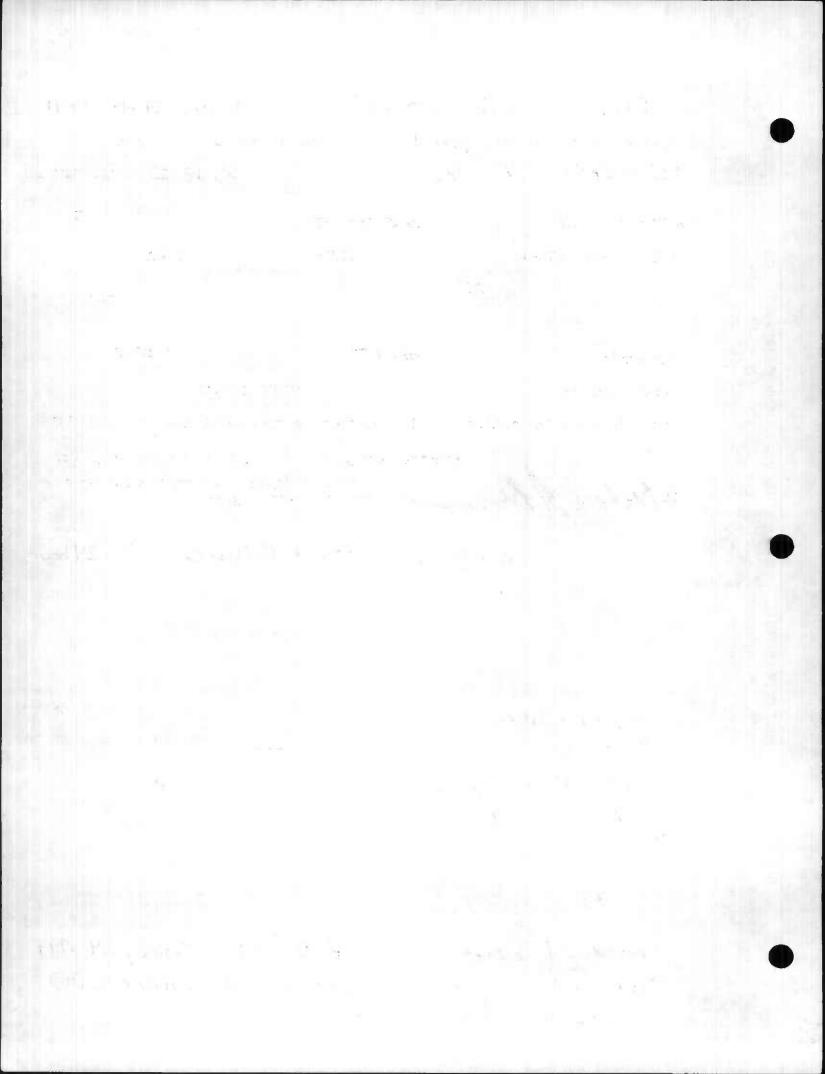
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the I 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Stinson 2 South Green St Baltimore MD Natasha 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

JAN 26 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day Nicholas 8:15 AM Gangemi Jan 24 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Days 1₽M 2□ F 105-01-4780 89 Yrs. 12/20/1909 RHODE ISLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 □ No HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Counfry? 6683 HAWKEYE RUN 21044 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 25 No Specify: WHITE 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondery (0-12) BAKER 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) (CAMPANELLO) ANTONIO GANGEMI ROSA 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6683 HAWKEYE RUN COLUMBIA, MD 21044 ROSE G. EDWARDS (DAUGHTER) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1XX Buriel 2 Cremation 3 Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) ROUND HILL CEMETERY 1/28/99 FELTON, PENNSYLVANIA 22. Name and Address of Fecility WITZKE FUNERAL HOMES, INC. 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045 Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting in death) stroke Due to (or as e consequence of) ypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or es e consequence of): Due to (or es a consequenca of) resulting in deeth) Last brauch block 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior fo 24e. Wes an autopsy completion of cause of death? 21300 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Ninpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury et Work? 1 Netural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifie 29c. License number mo Jan 24.

Division of Vital Records, P.O. Box 68760, certificate Physician: this funeral After or Attending aftar death. Director: / 24 hours a Hospital within 2 the 2

> State Registrar

DHMH 16 Rev 6/95

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

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r is marked other than "natural", or items 23e or 28a-f ehow traumstic event, the Medical Examiner main be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiena. Important: if item 27 is marked other than 'naturel', or flems 23e any Injury or other traumatic event, the Medical Experiment 23 bibbs.

Physician /Medical

Examiner

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30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

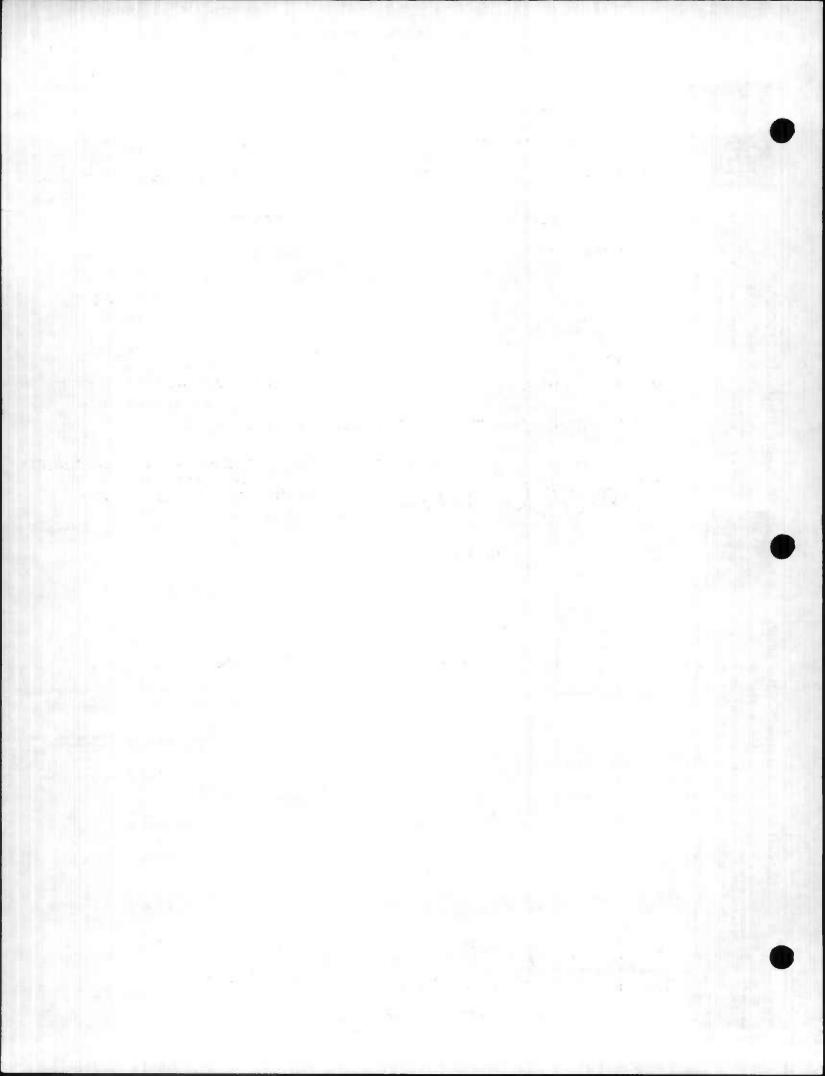
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32. Registrer's Signeture

Dr.

Columbier

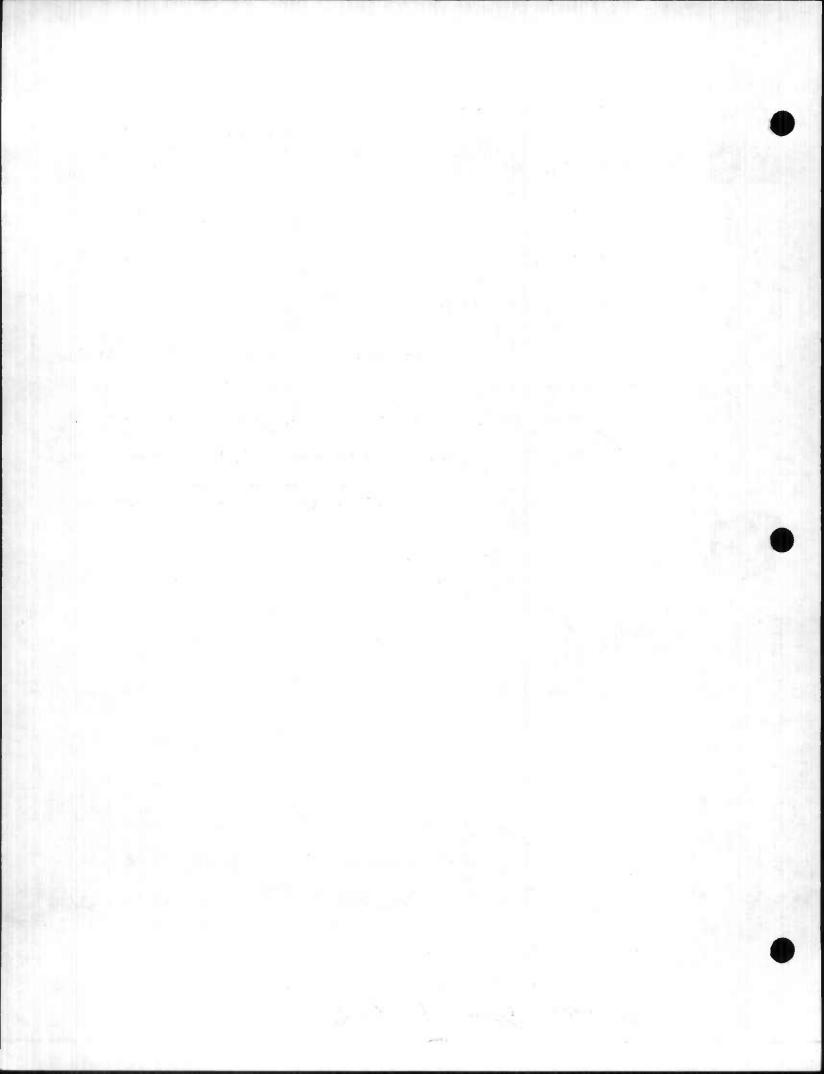
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State of Maryland / Department of Health and Mental Hygiene ()

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	Examiner	4a Facility Name (If not ins	-	e street and nu morial		n 1				or Location of I	Death 4c	4c. County of Death				
I		5. Social Security Number	6. S				f Lind	ler 1 Year			d Dieb					
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	D and T is my	19a. Informant's Name/Re Joanne B.			(6					o <i>r Rural Rou</i> te N Baltimor						
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	t. Pages 1 and 2 itment of Health. relant. If them 27 in injury or other tra	1 Burial 2 Crem 4 Donation 5 Ot	ation 3 🗆	Removal from	State		crematory or Mount			1/26/9				Maryland		
	Sparing My in My in	21. Signature of Funeral S	ervice Licen	1 -+	00		22. Name :	and Addre	ess of Facility Seitz.	Jr. Fur	neral I	Home				
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F	Physician /Medical															
ı	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Large Cell Lung Cancer Due to (or as a consequence of): Cerebral Vascular Acadent Two Weeks												Eight Minters		
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	icate be secuted physician and s the burist-tracsit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): c. Due to (or as a consequence of):												, , ,		
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	by the ache	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							230.	23b. Did tobacco use contribute to the ca			robably 4 Unknown			
5	oned se de by P															
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	clan: ector, Be	25. Was case referred to mexaminer?	-	Hospital:				0		Death (Check	only one)					
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	d in the										or Town, Stat	e)				
2	Funeral Rely filled															
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	within 2 To the	29b. Signature and title of certifier 29d. Date signed (Month, Day,														
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	1011	30. Name and address of p		completed caus	e of death (Ite	m 23a) (Ty	rpe, Print)	Han	nita /							
	State	Valerie Gre 31. Date flied (Month, Day,			lmon degistrar's Sign		wrial	1105	rical				_			
	State Registrar	JAN 2.6		Kal	wa	6	Ana	Kal	,							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item#5 per FH G767 1/26/99 EW 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 23 1999 Rebecca Gaither Jan 7:00pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner 2326 W. Mosher Street Baltimore If Under 1 Year | If Under 24 Hrs. 5. 640 pal Security Number 217-03-5627 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2□ F Months Deys Hours 88 Yrs. Director Feb 9 1910 MD Usual Residence of Decedant with the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d, Inside City Limits rait, or items 23s or 28s-f show Examiner imust be notified at MD NA Baltimore Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2326 W. Mosher Street 21216 USA Funeral filed within 72 hours efter death Hyglene. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian. Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: "natural", or 1 Yes 2 No Specify: þ 3€Widowed 4 Divorced Black permit. Pages 1 and 2 should be filed within 72 hc Depertment of Heelth and Mental Hyglene. Important: If item 27 is marked other than "naturu any injury or other traumatic event, the Medical Engle. Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondary (0-12) Collega (1-4or 5+) 10th NA Housewife PrivateHome 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Mary Lewis Perry Wright 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 21216 Donald Gaither - Son 2301 Calverton Heights Ave. Balto., Md 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Harmons, Md 4 ☐ Donetion 5 ☐ Othar (Specify) St. Rest Cemetery 1-28-99 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility MARCH FUNERAL HOME WEST, INC. 4300 WABASH AVE. BALTO., MD 21215 23a. Pert1. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or raspiratory arrast, shock, or hear fellure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Heute Myscerdial Infanction
Due to (or es e consaquancabi): Immediete Ceuse (Finel diseese or condition resulting in death) /Medical Erno Examiner Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to Immediate causa. Entar Undarlying Ceuse (Diseasa or injury that initieted events resulting In daeth) Last Dua to (or es e consequence of): The law requires that the death certificate Due to (or es e consequence of): signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ YUnknown þ 24b. Were eutopsy findings eveileble prior to complation of cause of deeth? should 24e. Wes en eutopsy performed? Completed Hyperlipi demia director, page 2 2 50No 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Wes cesa rafarrad to medical examiner? Be 26. Place of Deeth (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 10 1 Yes 2 No this funeral 28b. Time of Injury 27 Manner of Deeth 28d. Dascribe how Injury occurred 28c. Injury at Work? Certification: 28e. Dete of Injury (Month, Dey Year) 5 Pending 1 Naturel 1 Yes 2 No death. Investigation 2 Accidant after death Director: / 6 Could not be datamined 3 ☐ Suicide 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 Homicida within 24 hours after To the Funeral Dire completely filled in b 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and plece, end due to the causa(s) and manner as ateted. edicai 2/ Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, daeth occurred et the time, data and piece, and due to the ceuse(s) end manner stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certain 29c. License number 0 Bal D-40521 lelon Jonnary 25, 1999

State Registrar

31. Date filed (Month, Day, Yeer) 2 6 1999

DR. OCHANET

32. Registrer's Signature

Battinore, MD

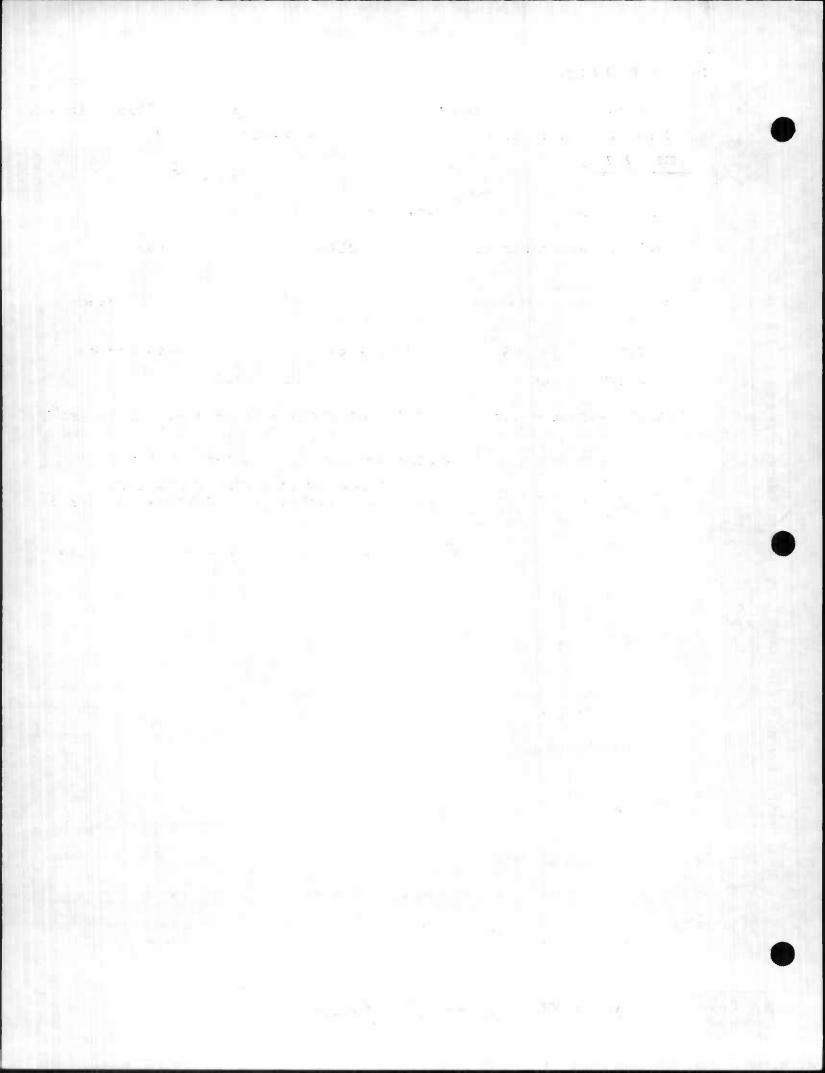
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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 3350 Wilkews Arenue Sunte 302

DHMH 16 Rev 6/95

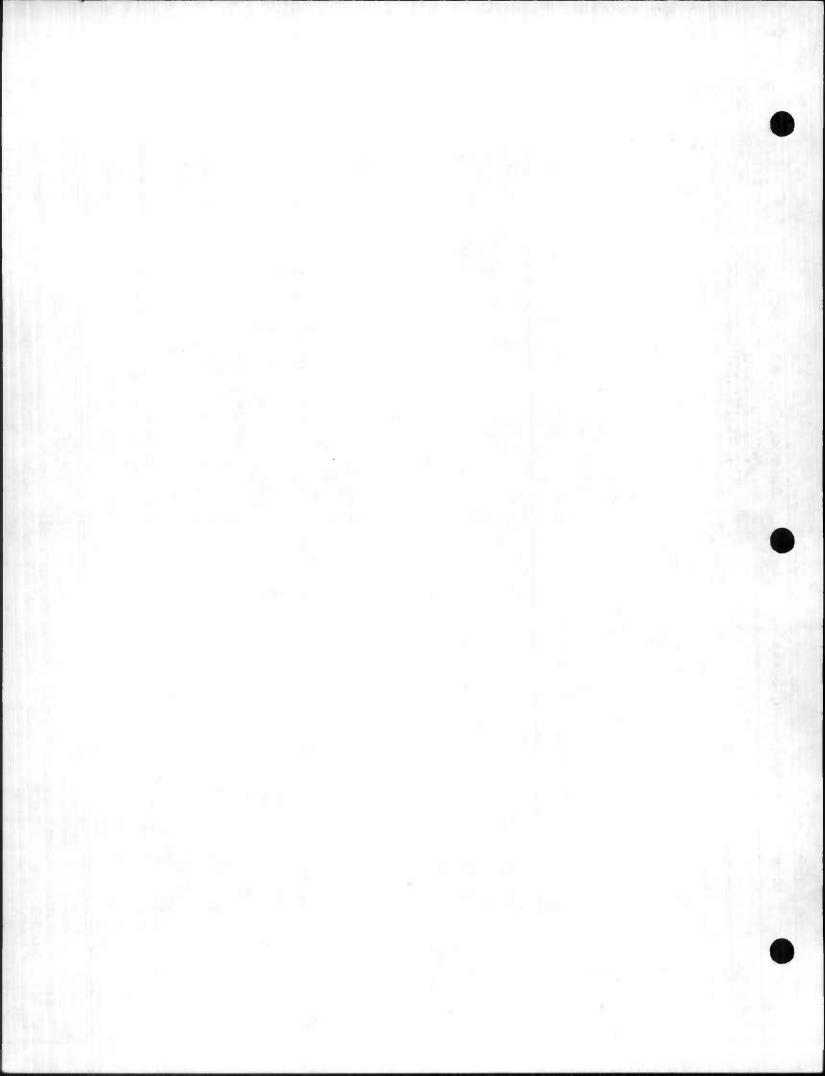
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



					Cert	ificate of	f Death	R	ig. No.		
	D1 11		Decedent's Name (First, Middle, Last)					2. Date of Deat	2. Date of Death Month Day Year		3. Time of Death
	Physician /Medical	Ruth Estelle Geiman						Januari	1 24, 1	999	10:50 AM
	Examiner	4a Facility Name (If not institution, g	ive street and number	7)			4b. City, Town, or	Location of Death	4c. County	of Death	
47		Franklin Square	Hospital	Cente	er		Rosedale			etimo,	
	Funeral Director	5. Social Security Number 213-03-6884 Usual Residence of Decedent	Sex 1 □ M 2 □ F	ge (In yrs. 88		If Under 1 Yes Months Day			Year) 4,1910	9. Birthplac Country Mary	ce (State or Foreign) Land
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21215-0020 d within 72 hours at	ypiene. ser than "natu rt, the Medical Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 8th Grade	rade completed)	ucation de completed) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Cashier		rorking		usiness/Industry Utility	
and	Be son	17. Father's Name (First, Middle, La John Wilson	st) King	7-2-				me (First, Middle, A Estelle			
Ja di	To To	19a, Informant's Name/Relationship			19b. Mailing	Address /Stre	1	Tural Route Number			iode)
N S	10 mm	Mr. Thomas E. Ge		and)				Apt. 3114,			
6 .	Hem office	20a. Method of Disposition	4,1-2-4,	20b. F	Place of Disposit	ion (Name of			20c. Location -		
Page P	min m	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	2 Cremation 3 Removat from State Cometery, Crematory or other place) Lakeview Memorial Park 1/28/99 Syke						Subonvi	resville. Maruland	
alt alt	arte di sarte	21. Signature of Funeral Service Lic		2001	22.1	lame and Add	ress of Facility			· ·	Tartyrana
00 3	SEES	Mark T. Z	RVOURL		So	himune	k Funeral	Home, IV Baltimore	ic.	21236	
		23a. Pert1. Enter the disease, or co shock, or heart failure. List on		d the deat	h. Do not enter	the mode of d	ying, such as cardie	ic or respiratory arm	est,		Approximate nterval Between
1	nysician Medical xaminer	Immediate Cause (Final disease or condition resulting in death)	a. Aspi	vete Due to (o	or as a conseque	eu ma	···			4	hrs
Box 68760, eath certificate be executed	attending physician and if for use as the burist-transit clan/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. (& V) c	Due to (o	r as a conseque	nce of):	acciden	X			Y
. 5	d for	Part II. Other significant conditions	contribution to death	ntributing to death but not resulting in the underlying cause given in Part t.					bacen usa enr	atribute to t	he cause of death?
م ا	ed by the attending deteched for use a Physician/M		out thousand to doubt	out for fooding with a thought yard cade great art are to			1 D Y	and the		bly 4 Unknown	
Records, P	should be							24a. Was a perform		avail	e autopsy findings lable prior to pletion of cause
I Rec	page 2							400	V.	of de	
= -	certificate rector, pag	25. Was case referred to medical						1046	15 212/10	10	Yes 2□ No
of Vital	irector,	examiner? 1 Yes 2 7 No	Hospital:		ER/Outpatient	-C	Whor	ath (Check only on		40 41	
	rithis and di	27. Manner of Death	28a. Date of Ing (Month, D		28b. Time of	3 DOA 28c. tn	4LI Nursing	Home 5 Reside			
Vision	th. : After th s funeral	Natural 5 Pending 2 Accident investigati		ay Year)	Injury		lork? □Yes 2□No				
5 8	T SP	3 Suicide 6 Could not determine	A 286. Place of it	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				281. Location (Street and Number or Rural Route Number, City or Town, State)			
	24 hour Funer stehy fill dical	29a. Certifier (Check only one) Certifying F	hysician: To the best iminer: On the basis of and manner s	of my kno- of examinal tated.	wledge, death o tion and/or inves	ccurred at the stigation, in my	time, date and place opinion, death occ	e, and due to the coursed at the time, do	ause(s) and ma ate and place, a	nner as stat and due to t	ed. he cause(s)
70 5	To the complete	29b. Signature and title of certifier	Russel	W	7	29c. Lice	30187	2	9d. Date signed		
	10	30. Name and address of person who	completed cause of		23a) (Type, Pr	im) al the	Bluz	Balt A	10 2	1123	,4
	State	31. Date filed (Month, Day, Year)	1999 32. Regis	ar's Signa	ture 4	1					

DHMH 16 Ray 6/95

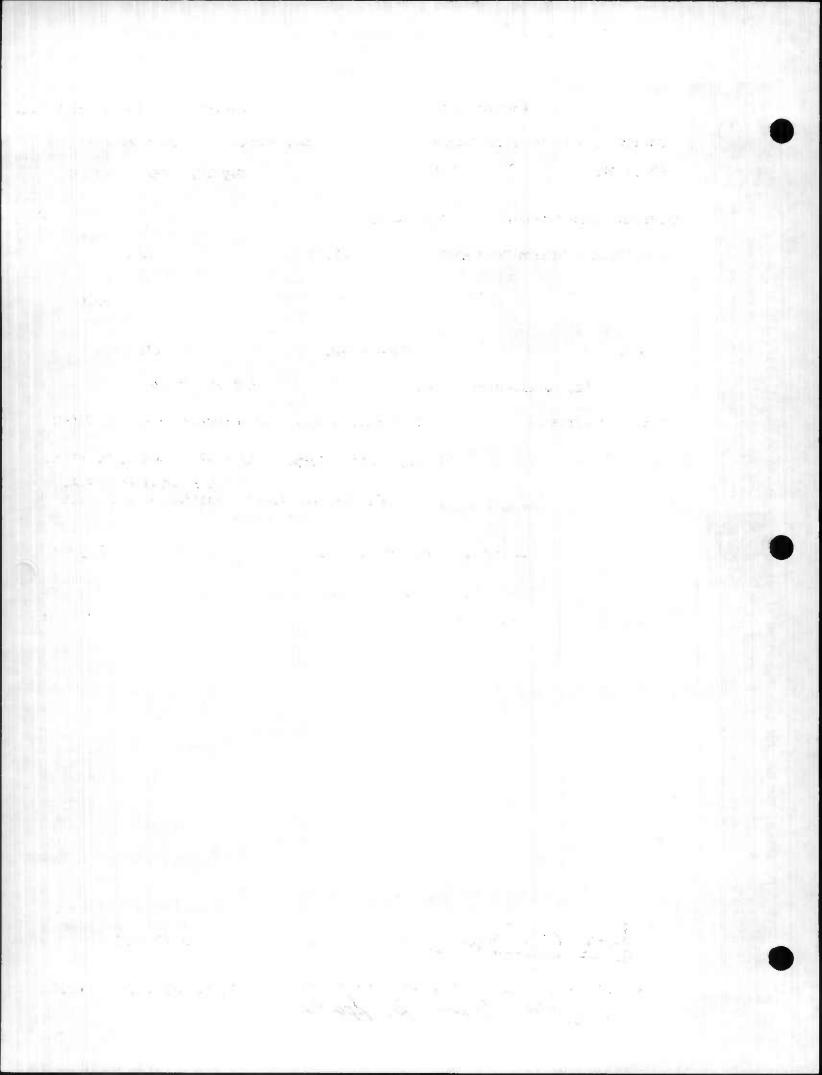


	Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death								3. Time of Death		
Physician /Medical	1. Dooddall o Hall o prost, whole,	Kaeth	he Greb			Month Day Ye		999 8:50 P.M			
Examiner	4a Facility Name (If not institution,	TO THE STATE OF					r Location of Death				
uneral	Mariner Health 5. Social Security Number		7. Age (In yrs. i		If Under 1 Yea		s. 8. Dete of Birt		Arundel 9. Birthplace (State or Foreign Country)		
irector	562 42 5926	1□M 2ÅF	102	Yrs.	Months Deys	s Hours Mir	May 29,	1896	Poland		
	Usuel Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. inside City Limits		
leted by Funeral Director	Maryland Anne A	runde1	G1	en Bur	nie				1 ☐ Yes 2X No		
Directo	10e. Street end Number		10f. Zip Code		10f. Zip Code			10g. Citizen of V			
a l	7355 Furnace Bi				210			U.S			
Funeral	11. Marital Status 1⊠ Never Married 2□ Married	Armed For	12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2X No		if Yes, specify Cu	ban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	Bied Bied	e - American Indian, ck, White, etc.		
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	If Yes, Give 12 Year or Dates:			1 ☐ Yes 2 ☑ No Specify:			White		
eted	15. Decedent's (Specify only highest		ation 16a. [ocedent's Usual Occupation five kind of work done during most of working e. DO NOT use retired)		orking	16b. Kind of Bu	usiness/Industry		
Completed	Elementary/Secondery (0-12)	-4or 5+)	_	mstress	90)		Clot	thing			
Be Co	17. Fether's Name (First, Middle, La	ast)					ame (First, Middle,		ne)		
10		available	e)	Greb			(Not available) Ther or Rurel Route Number, City or Town, State, Zip Code)				
	19a. Informant's Name/Relationship Vincent Yastrze										
	20e Method of Disposition 20b, Placa of Disposition (Neme of Date 20c, Location - City of										
	1 Burial 2 X Cremation 3 Removal from State 4 Donetion 5 Other (Specify) acametery, cremetory or other place) Hilltop Service Corp. 1/26/99 Towson,								n, Maryland		
DUCE.	21. Signature of Funeral Service Licensee 22. Name end Address of Facility Gonce Funeral Home P.A.										
a	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.										
	23a. Part1. Enter the disease, or 5 shock, or heart feilure. List of	omblications that ca by one cause on e	aused the death ech line.	h. Do not ent	er the mode of dy	ying, such es cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset end Deeth		
ו	immediate Cause (Final disease or condition Coronary Artery Disease										
r	disease or condition resulting in death) a. Due to (or as a consequence of):										
- Julei		b. Esser	ntial	Hyper	tensio	n			5 years		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Seni	Due to (o	ras e conseq entia					12 years		
7	that initiated events	c		r es e conseq					-		
Med	resulting in death) Last		d								
lan		- 0.							i		
Physician/Medic	Part II. Other significant conditions contributing to death but not resulting in							id tobacco usa contributs to the cause of death Yee 2□ No 3□ Probably 4□ Unknow			
by P							-	Yee 2□ No X			
peted								an autopsy rmed?	24b. Were autopsy findings evailable prior to completion of cause		
Completed		57111						V	of death?		
	25. Was case referred to medical					OC Disease of D		Yes 2 No	1 Yes 2 No		
To Be	exeminer?	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of	28a. Date of Injury (Month, Dey Year) Injury Work?						red		
catl	2 Accident investiga 3 Suicide 6 Could no	t be	M 1 Yes 2 No				28f. Location (Street end Number or Rurel Route Number,				
Certification:	4 ☐ Homicide determin	ed 28e. Place buildir	ng, etc. (Specif	y)	reet, factory, office	9	City or To	vn, State)	or rigidi riodio ivalidor,		
O		Physician: To the							anner as stated. end due to the cause(s)		
ca	(Check only 2 Medical Ex							breadl			
completely filled in Medical Cert	(Check only 2 Medical Exone) 29b. Signeture and little of certifier	and mann				nse number		29d Date signs	nd (Month, Dey, Year)		

Registrar

State gistrar JAN 25 1999

32. Registrer's Signature B. Sparks



Examiner The law requires that the death certificate be executed

and attending physician for use as the burie Box 68760. P.O. I signed t Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director; p

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f ahow

Herne ;

permit. Peges 1 and 2 should be filed within 72 hours after Department of Healin and Mentel Hygiene. Introductant: If Itam 27 is marked other than "natural", or he any injury or other traumatic avant, the Mentel Enuring

Physician /Medical

Physician/Medical Examiner

Completed

Be

Baltimore, Maryland 21215-0020

Director

Funerai

Completed

Medical Certification: To REP Registrar **DHMH 16 Rev 6/95**

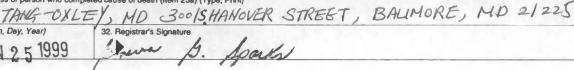
QING 31. Dete filed (Month, Dey, Year) State

29b. Signeture end title of certifier

29a. Certifier (Check only one)

JAN 2 5 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



MD Resident Physician

ORIGINAL

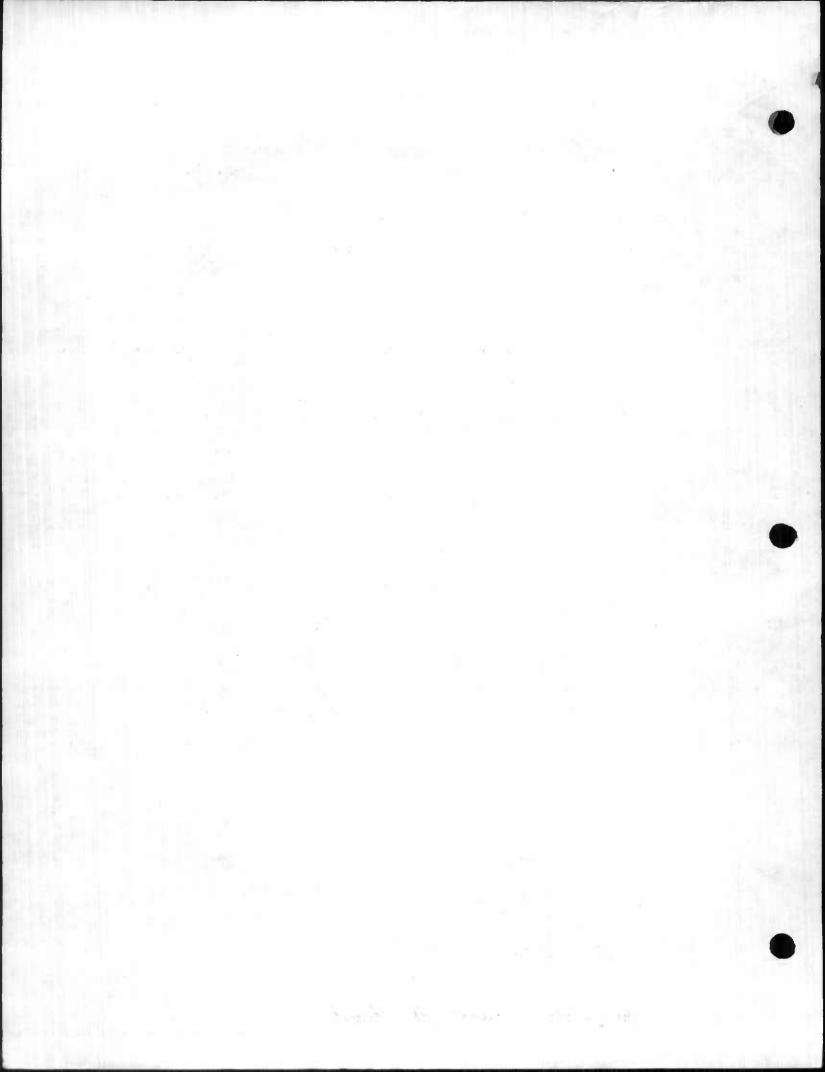
Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated.

29c. License number

P12136

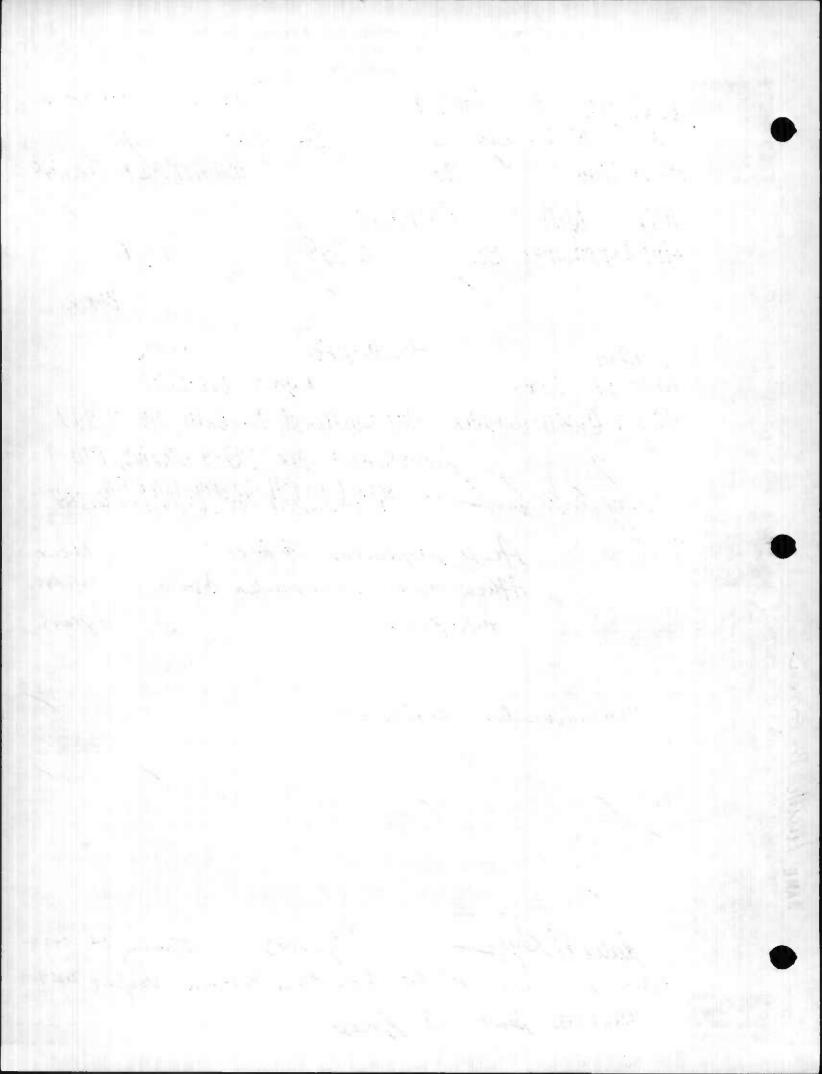
29d. Date signed (Month, Day, Year) January 23, 1999



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death TANTARY **Physician** 1999 0930 AM /Medical 4b, City, Town, or Location of Death 4c. County of Death **Examiner** If Undar 24 Hrs. last birthday) 10 M 200 F Deys Hours Yrs. Director Usual Rasidance of Dacedant 10a. Stete 10b. County City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Director 10f. Zip Coda 10g. Çitizan of What Country? 10e. 122 Funerai Wes Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Rece - American Indian. 11. Maritel Status Black, White, etc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Married 1 Yas 2 No altimore, Maryland 21215-0020 Specify Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation
(Giva kind of work dona during most of working
| lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Il Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) ith and Mental Hygie 27 is marked other r trsumatic event, if permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event page. To Be Jeremiah Bal 20a. Methed of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 Donation 5 Other (Specify) 21. Signeture of Pureral Service Licensee plications that caused the deeth. Do not enter the one cause on each line. Approximata Intarval Batween Onset and Death **Physician** tmmediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Physician/Medical Examiner sclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last physician s the buna Kusun Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Cerelm vuscular þ 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 1 Yas 2 No 1 Yas 2 No NAME Lucille Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Yas 2 No To 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manne of Death 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicida 28a. Place of Injury - At home, farm, straet, factory, office building, atc. (Specify) 4 - Homicida To the Hospital
within 24 hours a
To the Funeral C 1 critifying Phyeicien: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) 29a. Certifian Medicai and mannar stated. 29d. Date signed (Month, Day, Year) 29b. Signetura a 29c. Licanse number 24, 1999 Tamuru address of person who completed cause of death (Itam 23a) (Type, Print)

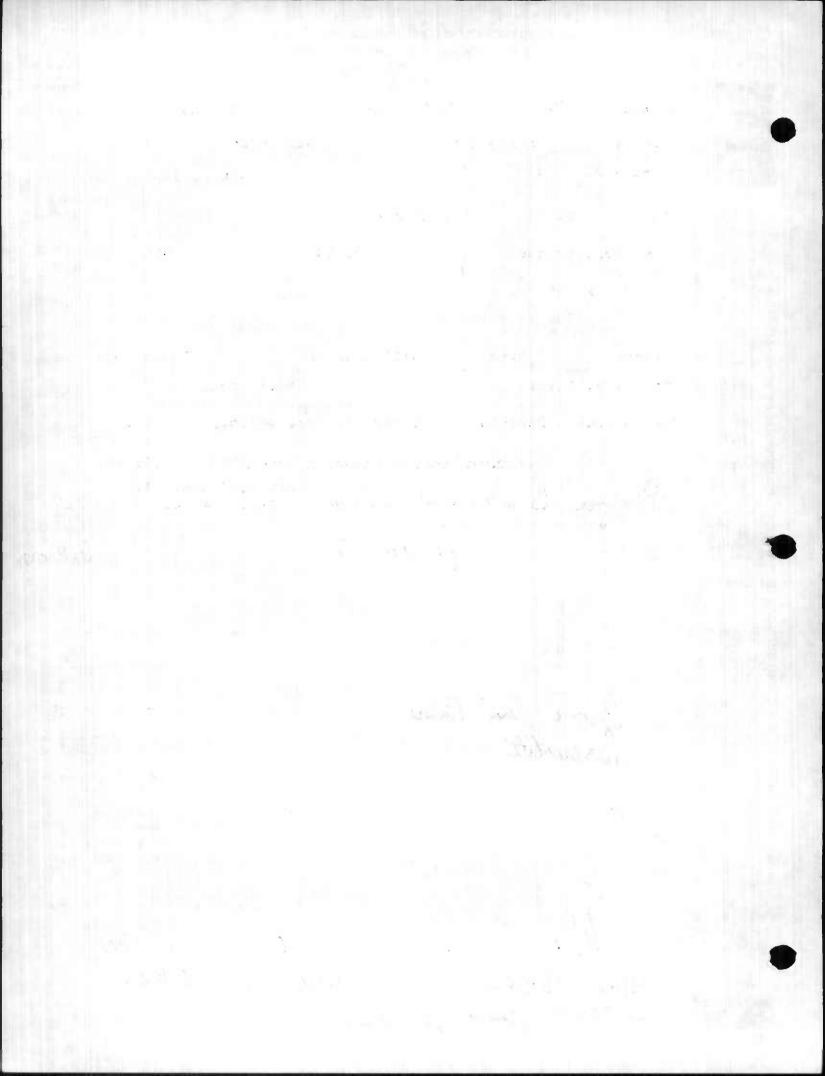
14. SCRUGGS MIN) 900 Ca fon Bulfmore Maylowl H. SCRUGGS Nonne CEVIN 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State Registrar JAN 2 6 1999



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State of Maryland / Department of Health and Mental Hygiene 9 9 7

	an Sagar Malia 1941		Certificat	e of Death	Re	g. No.	01721		
Physician	Decedent's Name (First, Middle, Last)	IN HUNDER			2. Dete of Deeth Month		3. Time of Death		
/Medical	Daniel E.	Harris	III		Jan 23				
Examiner	4e Facility Neme (If not institution, give street	et end number)		4b. City, Town, or	Location of Death	4c. County of	Deeth		
	Future Care Nurs			Baltim		NA			
Funeral Director	5. Sociel Security Number 6. Sex 1219-10-1756 12 M	2□ F 7. Age (In yrs. last 73	Yrs. If Under Months	1 Year If Under 24 Hrs Deys Hours Min	. (Month, Day,	Year) 1925	D. Birthplece (State or Foreign Country) MD		
pu	Usuel Residence of Decedent 10e. Stete 10b. County	10c City To	own or Location				10d, inside City Limits		
ith the Marylar or 28a-f show a notified at	Md NA		imore				1 ☑ Yes 2 ☐ No		
uth with the Maryla 23a or 28a-f should be notified at real Director	10e. Street end Number 6 Benkert Avenue		10f. Zip	Code L229	10	g. Citizen of Wh	et Country?		
urs after dea al', or items txemper m by Funer	1 □ Never Married 2 Married	Ves Decedent Ever in U,S. Armed Forces? Yes 2 No Yes, Give Yes, Give	13. Wes Deced If Yes, spec	dent of Hispanic Origin? (i cify Cuben, Mexican, Pue 2 No Specify:	Specify Yes or No- rto Rican, etc.)		American Indien, White, etc. BLACK		
		mpleted) College (1-4or 5+)	'life. DO NOT us	rk done during most of we se retired)	orking	6b. Kind of Busin			
filed with Hygiena. Hyber than and, the		Byrs	Mail Har				Service		
De dot Hall H	17. Fether's Neme (First, Middle, Last) Daniel E. Harris				ame (First, Middle, M	e <i>iden Sum</i> eme)			
1 and 2 should be filled within the thath and Mental Hygiera. Item 27 is marked other than other traumatic event, the Mental Hygiera. To Be Compl					Prout				
Mall yiding 42 should be file th and Mental Hy 7 is marked oth traumatic event To Be (19e. Informent's Neme/Reletionship (Type,			(Street end Number or F					
is 1 and of Health item 27 other to	June Lawson - Day 20a. Method of Disposition		o Benker a of Disposition (Nar	t Ave. Ba			ty or Town, Stete		
0 0 0 2 2	1 Burial 2 Cremetion 3 Remo	val from State ceme	etery, cremetory or o	ther placa)		altimo			
permit. Page Department of Important: If any injury on	21. Sign, jure of Funeral Servica Licensee	2	22. Name en MARCH	d Address of Fecility FUNERAL	HOME WES				
	23e. Pert 1. Enter the disease, or complication shock, or heart value. List only one complications are complicated to the complex of the comp	ons that caused the death. F	4300	WABASH AV	E. BALT	O., MD	21215 Approximate		
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	(ws	the (Ch			interval Between Onset end Deeth		
tificate be associted g physician and as the bunk-transit	Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Disease or Injury c.	b							
E 0.0	thet initieted events resulting In deeth) Lest Due to (or es e consequence of): d.								
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ires that the death certifications that the attending of be detached for use a by Physician/M	Pert It. Other significant conditions contribu	uting to death but not resulting	ng In the underlying c	ause given in Pert I.			ibute to the cause of death Probably 4 Unknow		
requirement hould	Puncientia	lenal Finlus Es			24a. Wes en		24b. Were eutopsy findings evailable prior to completion of cause of deeth?		
The law ate has b page 2 s					1 □ Ye	8 2 No	1 ☐ Yes 2 ☐ No		
certificate rector, pag	25. Wes case referred to medical			OF Disease of Di			10165 20140		
Physician: T this certificat ral director, p. T. To Be Co	exeminer?	itel: 1 Inpatient 2 ER/	/Outpetient 3□ DC	Othor	eeth (Check only one Home 5 Resider		(Specify)		
ng Phys tar this neral di				28c. Injury et Work?	28d. Describe ho				
To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	2 Accident Investigation	Be. Pleca of Injury - At home building, etc. (Specify)	М	1 Yes 2 No	28f. Location (Str. City or Town,		or Rural Route Number,		
To the Hospital or Attandi within 24 hours after death To the Funeral Director. A completely filled in by tha fi Medical Certificati	(Check only 2 Medical Examiner:	n: To the best of my knowled On the bests of examination	dge, death occurred and/or Investigetion	et the time, date end pled , In my opinion, deeth occ	ce, end due to the ca curred et the time, de	use(s) end menr te end place, an	ner es stated. d due to the ceuse(s)		
thin 2 the mpiet	29b. Signature and title/disefilier	and manner fleted.	200	. License number	200	d Date signed	(Month, Dey, Year)		
L X L O	1 // Moore	Min	290	Da 2// 6	29	117	149		
6	30. Name and appress of person who comp	apod cause of death (flore 23	la) (Type, Print)	(10)) (1)	Can 1/1	#2	1		
Oin	31. Dete filed (Month, Day, Year)	32. Registrer's Signeture	1938	siem (1	ee va	N 300			
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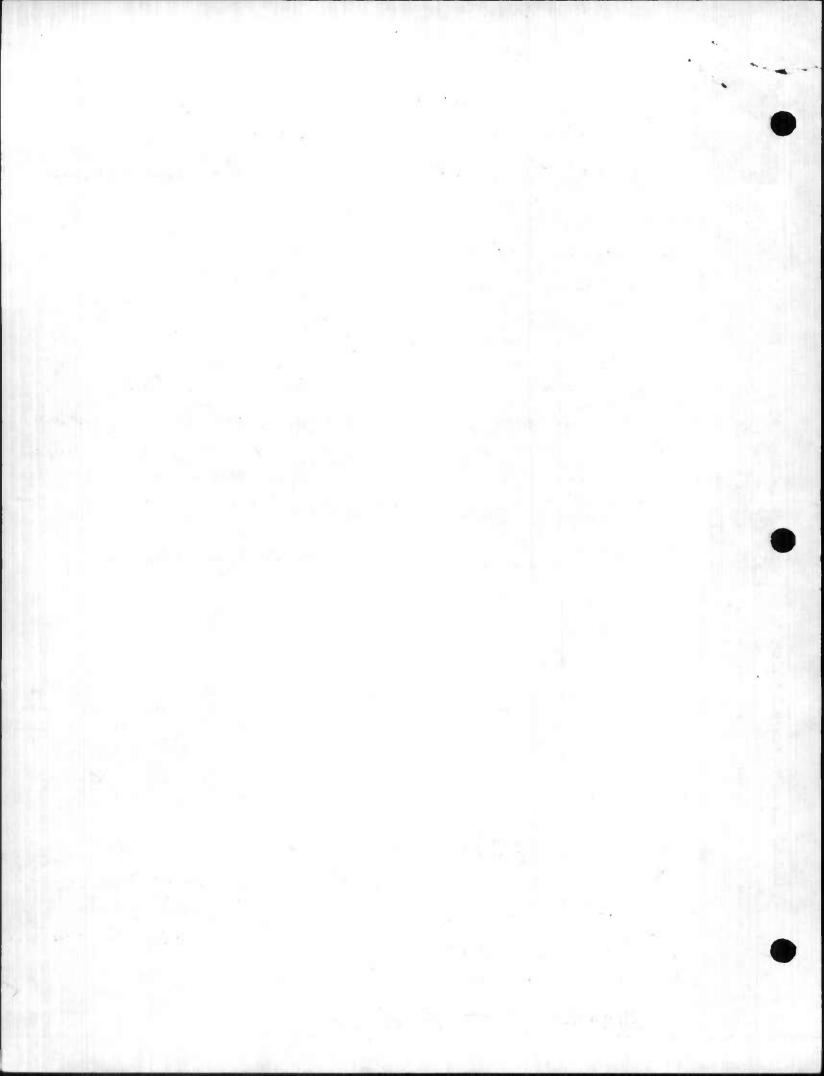
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State of Maryland / Department of Health and Mental Hygiene

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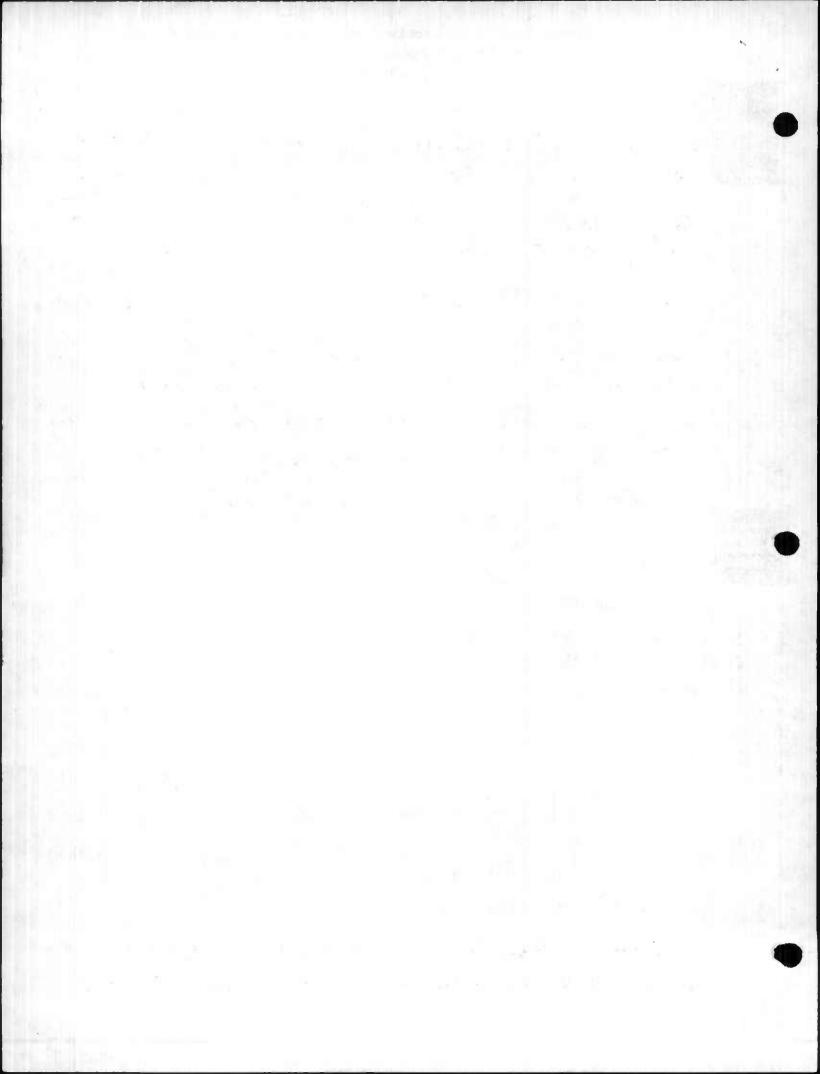
Physician		ddle, Last)			2. Date of Death Month	Day	Year 0120
/Medical	1 1 1 1 1 1 1 1 1	CTOR HEND	person, III		JANUA		1999 0130
Examiner		tion, give street and number) ILTON AVENUE			4b. City, Town, or Location of Death BALTIMORE		
Funeral Director	5. Social Security Number 2/5-74-3366	6. Sex 7. Age	(In yrs. last birthday) If Und 35 Yrs. Month	der 1 Year If Under 24 Hr Is Days Hours Mir		Year) 1963	9. Birthpiace (State or Gountry) Maky Areo
New man	Usual Residence of Decedent 10a. State 10b. Cour	nty /	10c. City, Town or Location				10d. Inside City
the Marylar 28a-f show notified at	Manylow	N/B	BALA				1. Tes
death with the Maryland ms 23s or 28s-f show marsi Director	35/7 CHES	TERfield A	Zip Code 2/2/3	10g. Citizen of What Country?			
ar, or he	3 ☐ Widowed 4 ☐ Divorce	12. Was Decedent El Armed Forces? arried 1 Yes 2 No	ver in U,S. 13. Was Dec	cedent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		e - American Indian, k, White, etc.
be filed within 72 hours after tal Hyglene. I other than "natural", or ha avent, the Medical Examina Be Completed by Fu	15. Deced (Specify only high Elementery/Secondary (0-12	ent's Education hest grade completed) College (1-4or 5+	life. DO NOT	work done during most of w	orking		siness/Industry
	17. Father's Name (First, Middle)	HENDERSON,	JR.	_ /	ame (First, Middle, M		•
N TO S	19a. Informant's Name/Relation CHERASE M		1	ess (Street and Number or F	Rural Route Number,	City or Town,	1-
Pages 1 and ant of Haalth It: If Nam 27 y or other tr	20a. Method of Disposition	n 3 Removal from State	20b. Place of Disposition (A cemetery, crematory of US O OLDWA	lame of	Date 2	Oc. Location - 0	City or Town, State
permit. F Departm Importar any injur	21. Signature of Funeral Service		22. Name 52 40	and Address of Facility C. MELS TEYS how y	HATUAN	- HARE	iers Feneral i
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· 000	Jue to (or as a consequence of		eck and	Mido	nan
cate be executed physician and the burlat-transit cdical Examine	I thinke Single Chicotiffing	d .	ue to (or as a consequence o				
ficate be a physicia as the bur	Cause (Disease or injury that initiated events resulting in death) Last	d .					
ficate be a physicia as the bur	Cause (Disease or injury that initiated events resulting in death) Last	{	ue to (or as a consequence o	0:	23b. Did tob	.A.	stribute to the cause of
ficate be a physicia as the bur	Cause (Disease or injury that initiated events resulting in death) Last	{	ue to (or as a consequence o	0:		autopsy	
The law requires that the death certificate be as has been signed by the attending physicial page 2 should be deteched for use as the bur Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last	d	ue to (or as a consequence o	n; g cause given in Part I.	1 Ye	autopsy ed?	3 Probably 4 U 24b. Were autopsy fire available prior to completion of ca
clan: The law requires that the death certificate be settificate has been signed by the attending physicia edoc, page 2 should be deteched for use as the bur Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions to the condition of the conditions of the con	d. Distributing to death but	ue to (or as a consequence o	g cause given in Part I. 26. Place of D	1 ☐ Ye	autopsy ed?	3 Probably 4 U
hysician: The law requires that the death certificate be his certificate has been signed by the attending physicial director, page 2 should be deteched for use as the bur To Be Completed by Physician/Medical	Cause (Disease or injury that initiated events resulting in death) Last Part II. Other alignificant conditions to the examiner? 1 Sixes 2 No	d	not resulting in the underlying in the underlyin	26. Place of DOA Other: 4 Nursing 28c. Injury at Work?	24a. Was an perform 10 Yes eath /Check only one Home 5 Pesider 28d. Describe hor	autopsy ed? s 2 No noe 6 X Othe w injury occurry	3 Probably 4 U
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State of Maryland / Department of Health and Mental Hygiene

					Certificate d	of Death	Re	g. No.		
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	Us	uel Residence of Decedent a. Stete 10b. County		10c. City, Tow	n or Location				10d in	side City Limits
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alD		17306 BIG,	Falls R	CHA V	2,	1111		USA		
þ		Married Stetus 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 1 Yes, Give Year or Dates:	Ever in U,S.	13. Wes Decedent If Yes, specify C	of Hispenic Origin? (Scuben, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	Bleck, \	American tho White, etc.	
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Physician/	Par	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						pacco use contrit	bute to the c	ausa of death
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		4 Homicide determined	building, etc	. (Specity)	rm, street, factory, offic		28f. Location (Stre City or Town,	Stete)		e Number,
edical	296	a. Certifier (Check only one) 1 Certifying Physical Control (Check only one)	sician: To the best oner: On the basis of and manner sta	examination end	, deeth occurred et the Vor Investigation, In m	time, dete end plece y opinion, deeth occu	, end due to the ceu rred et the time, dat	use(s) end menne te end place, end	or es steted. due to the co	euse(s)
Me	29t	Signature and title of certifier	Wegner (6)		ense number 4184	29	d. Dete signed (M	fonth, Dey, Y	(ear)
	30. R	Name end eddress of person who co	mpleted cause of de	7801	D3 Type, Print) YOLIC RJ	#100, 70	WSON	mp 2	1204	L
tate	31.	Dete filed (Month, Day, Yeer)	32. Registre	r's Signature						



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔾 🔾 Item 19a Per FH Film G767 1-27-99 rja Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 25, 38 Jan. Gladys Jean Henry 2:22am /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2226 Cecil Avenue NA Baltimore If Under 1 Yaar | If Undar 24 Hrs. 8. Date of Birth Month Day, Yeer Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthday) **Funeral** Months Days Hours 1□ M 2√ F 87 Yrs. 217-07-9839 MD Director Usual Residenca of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Insida City Limits r 28a-f show Y Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 end 2 should be filed within 72 hours after death with I Department of Health and Mentel thygiene.
Important: If item 27 is marked other than "natural", or items 23a or 3 and Injury or other traumatic event, the Medical Exercities must be in page. 2226 Cecil Avenue 21218 USA Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Datas: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Dr. Gamble Nanny Unknown NA 18. Mother's Name (First, Middle, Maidan Surneme) 17. Father's Name (First, Middle, Last) Missy Johnson Unknown 19b. Mailing Address (Street and Numbar or Rurel Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Denise McCray Mc Crae 5 Milford's Garden Court Baltimore, MD.21244 20b. Placa of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State Baltimore Cemetery 01-29-99 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature of Funeral Service Licensae mand WM.C.March FH 1101 E. North Avenue Approximate Interval Between Onset and Daath 23a. Part 1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Examiner physician and the bunal-transit Saquantially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in deeth) Last Physician/Medicai Dua to (or as a consequence of): 88 for use as signed by the a d be deteched f Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of causa of death? s need 24a. Was an autopsy s certificete has director, pege 2 :

Physician /Medical Examiner

The law requires that the death certificate be executed

or Attending Physician:

director,

this

After

death.

after deatl Director:

To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th

Be

2

Certification:

Medical

29a. Certifier

Division of Vital Records, P.O. Box 68760

with the Maryland

Baltimore, Maryland 21215-0020

Completed

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No 26. Placa of Death (Check only one)

25. Was case raferred to medical axaminar? 1 Yes 2 No 27. Mannar of Death Natural 5 Pending

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 ER/Outpatiant 3 DOA 28b. Tima of 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 4 Homiclde

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Vertifying Physician: To the best of my knowledge, daath occurred at the time, date and placa, and due to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and til

29c License number

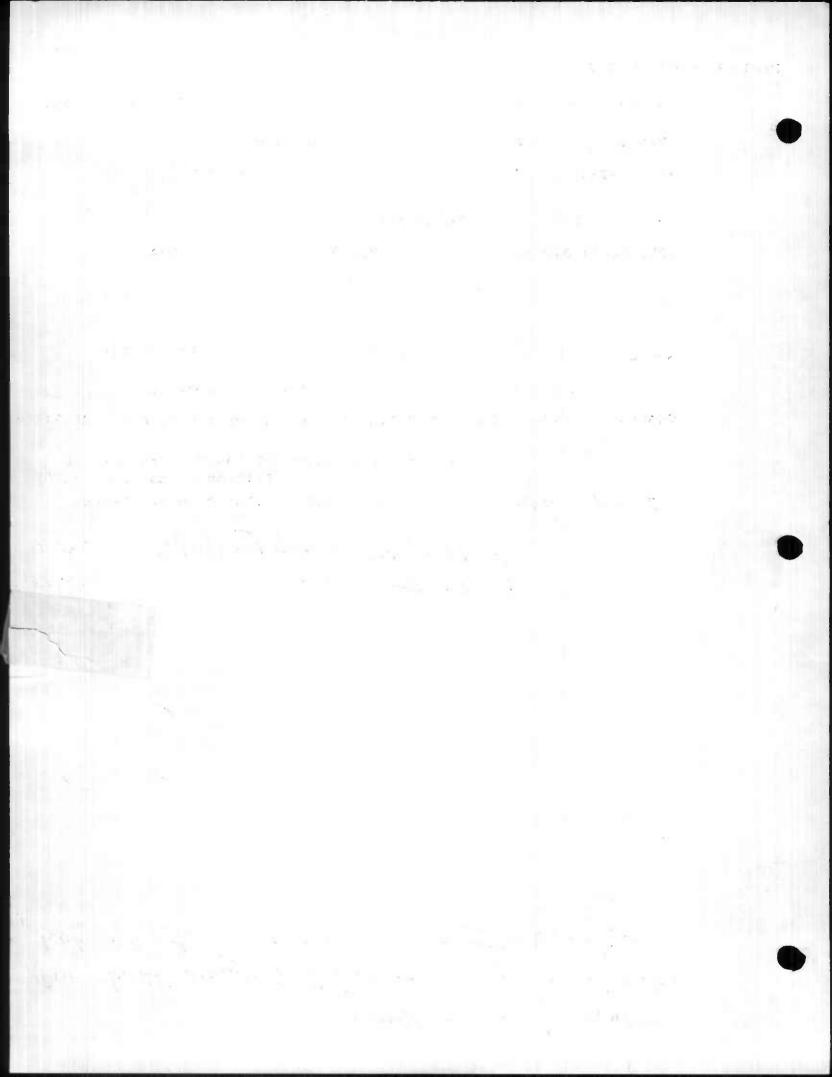
29d. Date signed (Month, Day, Year)

[AN 26, 199]

of person who complated causa of death (Item 23a) (Type, Print)
TREEN S DOING STVE. STE 301, Balt my 2/211. 00 LAWO/IN (TREENS

State Registrar 31. Date filed (Month, Day, Year) 26 1999

32. Registrar's Signature



Box 68760. Division of Vital Records, To the Hospital within 24 hours a To the Funeral Completely filled

Examiner physician and is the burial-trans certificate be Physician/Medical 88 use O the 6 signed b by Completed has director, Be To this funeral Certification: after death 3

Physician

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ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

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permit. Pages 1 and 2 st Department of Health and Important: If Itam 27 Is n any Injury or other traun page.

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State Registrar

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29a. Cartifiar

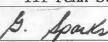
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29b. Signatura and titla of certifiar

Stephen Radentz, M.D. 31. Data filed (Month, Day, Year)

JAN 2 6 1999



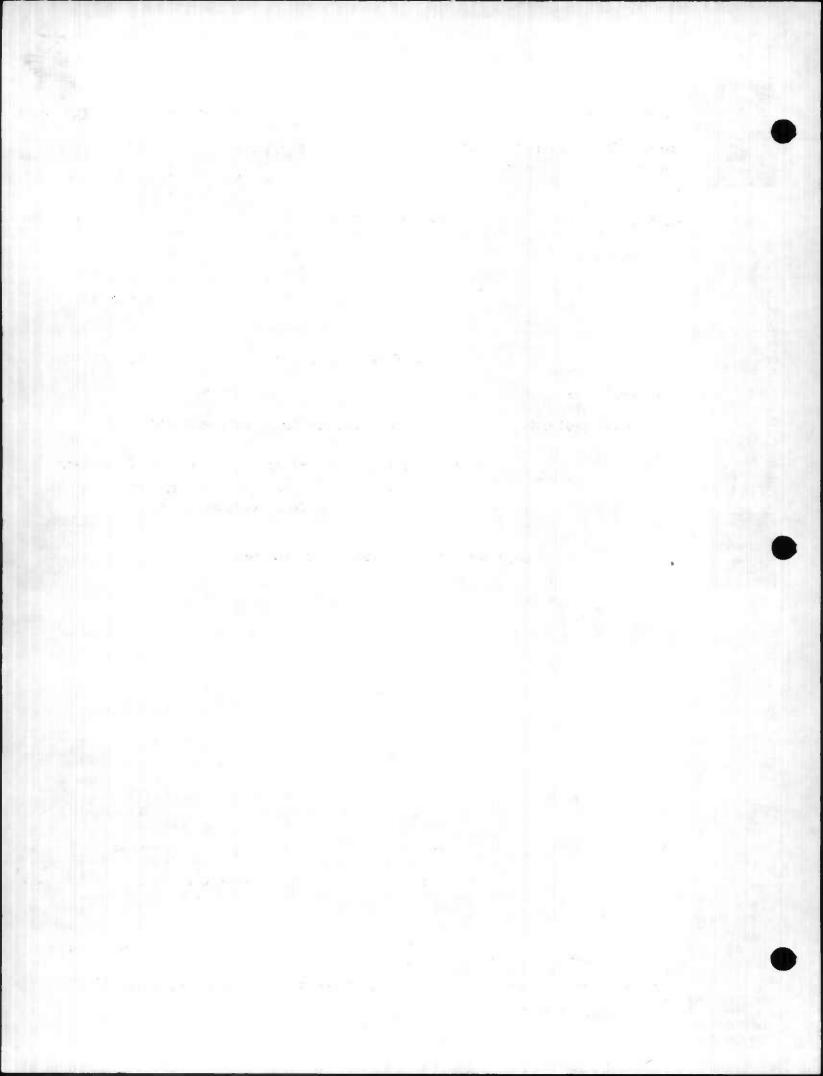


Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year) January 25, 1999 O.C.M.E. 30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

1 Cartifying Physician: To tha bast of my knowledga, daath occurred at the time, date and place, and due to the causa(s) and manner as stated.

DHMH 16 Rev 6/95

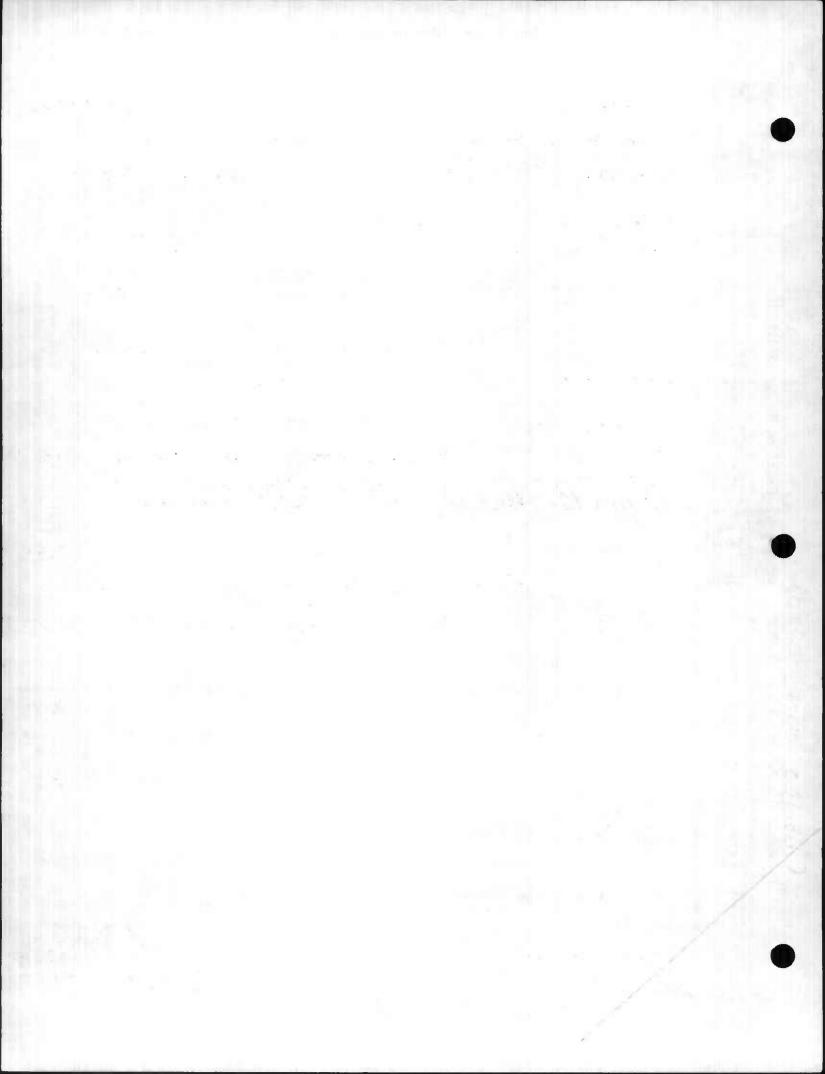
Hospital



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dala of Daath 3. Time of Death 1. Decedani's Nama (First, Middla, Last) **Physician** JANUARY Charles H. Harris /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, giva street and number) **Examiner** Union Memorial Hospital Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** 1 M 2 □ F Days Hours Yrs. 85 213-03-7357 Oct. 18,1913 **Director** Maryland Usual Rasidance of Dacedant the Meryland 10a Stala 10b. Count 10c. City, Town or Location 10d. insida City Limits XX Yas 2 No N/A Maryland Baltimore 10f. Zip Code 10g. Citizan of What Country? 10e. Street and Number i r than "natural", or items 23s or 2122 Druid Park Drive 21211 USA death v Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas ※ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 11. Marital Status Id be filed within 72 hours effer de ental Hygiene. ked other than "natural", or item ic event, the Medical Examples 1 Nevar Married 2 Married 1 ☐ Yas XX No Specify: Specify: White py π Yas, Giva Yaar or Dalas 3 X Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamanlary/Secondary (0-12) Collage (1-4or 5+) Machinist Hooper Mills 17. Falhar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Sumema) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if item 27 is marked oth
any liqury or other traumatic eventable. Be Frank Harris Freda Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) 6369 S. Locust Way Englewood CO 80111 John Harris Son 20b. Placa of Disposition (Nema of camatery, cramatory or other place) 20c. Location - City or Town, Stata 20a, Mathod of Disposition 1 Burial 2 Cremation 3 Ramoval from Stala Woodlawn Cemetery 1/25/99 Woodlawn, Maryland 4 ☐ Donallon 5 ☐ Olhar (Specify) 22. Nama and Addrass of Facility
Burgee-Henss Funeral Home PA 21. Signature of Funaral Sarvica Licenses 3631 Falls Road, Baltimore, Maryland optications that causad the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, one couse on each line. Approximata Injarval Between Onsal and Death Part1 Entar tha disease, or com shock the heart failura. List only **Physician** /Medical Immediata Causa (Final SPIRATION disaesa or condition rasulting in daath) Examiner Due to (or es a consequand Physician/Medical Examiner Sequantially list conditions, if eny, leeding to immadiata causa. Enter Undarlying Causa (Diseasa or injury thel initieted events attending physician end for use as the bunel-tran thet initieted events rasulting in daath) Last the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by þ 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy pege 2 s 1 Yas 2 No or Attending Physician: Be 25. Was casa refarred to medical examiner? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Mannar of Daath 28b. Tima of 28d. Dascribe how Injury occurred Certification: Injury Natural 5 Panding 1 Natural 2 Accidant 1 Yas 2 No Invastigation Director: / 3 ☐ Suicida 6 Could not be 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - Al home, ferm, straet, factory, offica building, atc. (Specify) 4 ☐ Homicide 29a Cartifian Macrifying Physician: To tha best of my knowledge, deeth occurred at tha Ilma, data and place, end due to tha causa(s) and menner as stated.
Madicat Examinar: On the basis of axamination end/or investigetion, in my opinion, death occurrad at the lime, dete and place, and dua to the cause(s) edical To the P 29d. Dala signed Month, Dey, Year) 29c. Licansa number 29b. Signati of death (Jasm 23a) (Type, Pfint) 32. Registr s Signature State Registrar

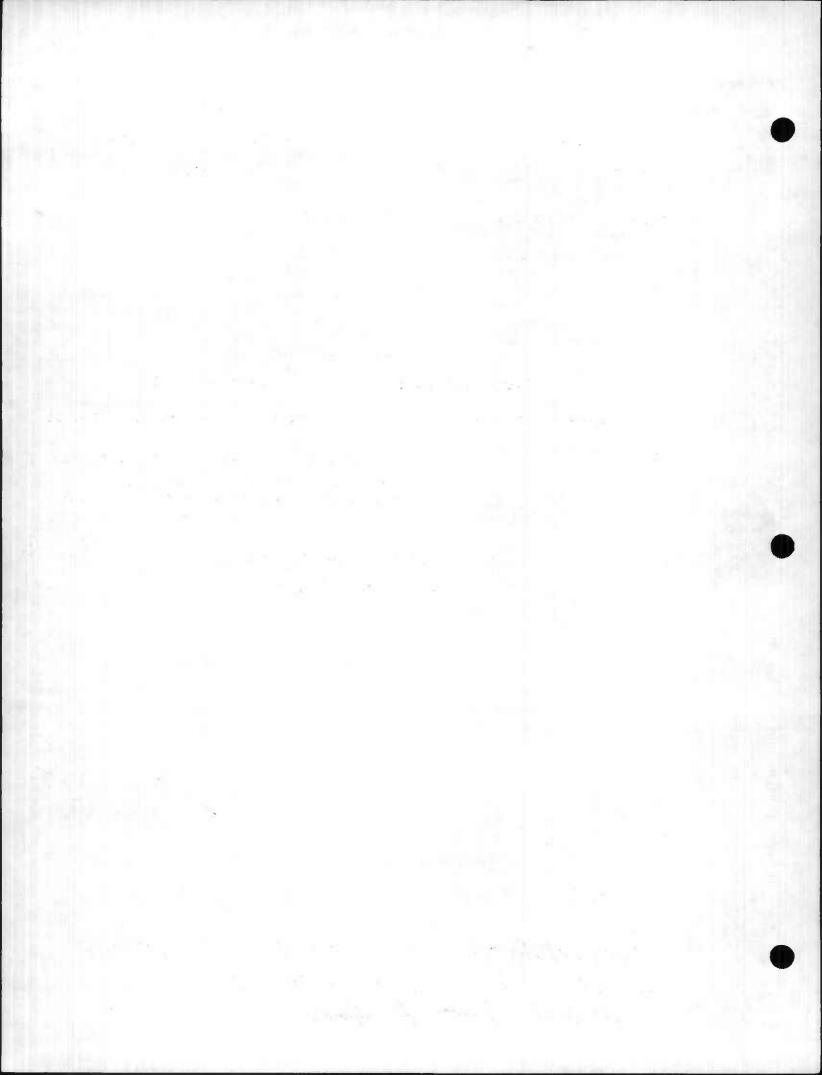


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24, 1999 12:55PM George B. Hoffman January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 48 Martinique Circle Ocean Pines Worcester Co. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In vrs. last birthday) Birthpiaca (State or Foreign
Country) **Funeral** Months 1 ☑ M 2 ☐ F Days Hours 80 Yrs. June 16,1918 Director Maryland 220-07-2925 Usual Residence of Deceden 10c. City. Town or Location 10a State 10h County 10d, Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 No Ocean Pines Maryland Worcester Co. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 48 Martinique Circle 21811 B Funer 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispanic OrigIn? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Biack, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married WWIT White Maryland 21215-0020 1 Yes 2 No Specify: py 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Turbine Operator BGE 11 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant: If hem 27 is marked oth 86 Charlotte I. Allen George C. Hoffman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19s. Informant's Name/Relationship (Type, Print) 48 Martinique Circle Ocean Pines, Maryland 21811 Janice Povloski Daughter Baltimore, 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 1 Burtal 2 □ Cremation 3 □ Removal from State ò Cedar Hill Cemetery Jan. 27, 1999 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Ligar 22. Name and Addrass of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 AAB. 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one ceuse on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Ceuse (Finei disaasa or condition resulting in death) Examiner Examiner buriel-tran Sequantiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last pug certificate be exer physician Physician/Medical the Dua to (or as a consequance of): 98 use 20 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 3 Probably 4 Unknown 3 1 Yes 2 No signed b þ 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Wes an autopsy Completed has page 2 Division of Vital Attending Physician: funeral director, 25. Was case referred to medical Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Panding investigation After Natural 2 Accident efter deeth. Director: Aff 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide ò 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number 30. Name ar ause of death (Item 23a) (Type, Prig 31. Date filed (Month, Day, Year, 32. Registrar's Sign State

Registral

JAN 26 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Charlotte Deloris Month Year Hoke 8:30 PM January 22 4a Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Deeth 7. Age (In yrs. last birthday) Roseda/e If Under 24 Hrs. 8. Date Franklin 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) Sept. 22,1920 5. Social Security Number Birthplace (State or Foreign Country) Days Months Hours 1□ M 2 F Yrs 293-16-7597 78 West Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21220 40 A. Cool Breeze Road United States 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Waitress Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Russell Harris Madge Boyle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Magdaline Mavrakis/Daughter 102 Kelly Ct. Wyommissing, PA 19610 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete MSBurial 2 Cremetion 3 Removal from State Gardens of Faith Cem. 1/27/99 Rossville, Maryland 4 ☐ Donation 5 ☐ Other (Specify). 21. Signature of Funer ²² Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate fnterval Between Onset and Death Immediete Cause (Final Hypercapnia 10 hours disease or condition resulting in death) Due to (or as a consequence of): hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Obstructive Pulmonery Disease! Chronic Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ir then "natural", or items 23a or 28a-f ahow the Wedical Examiner must be notified at

and Mentel Hygiene. Is marked other then

Pages 1 and 2 should be next of Health and Mentel

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Department of Important: If any injury or

Maryland 21215-0020

altimore,

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Division of Vital

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Certification: or Attending Fatter death.

Director: After

To the Hospital of within 24 hours af To the Funeral Discompletely filled in State Registrar

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Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case reterred to medicaf axaminer? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one)

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

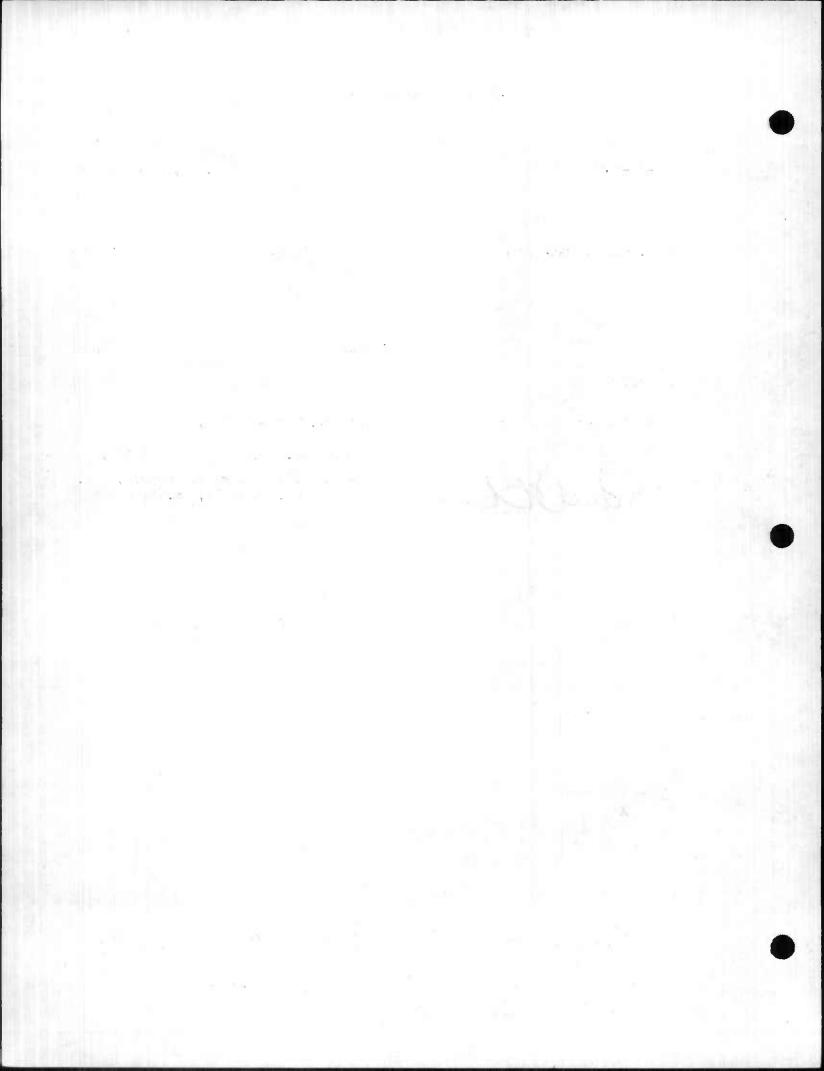
Baltimore, Maryland

Bhushan 31. Date filed (Month, Day, Year)

29b. Signature and Alleyof certifies

m.D. 9000 32 Registrar's Signature

Square Drive. franklin Darks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Year Physician Kathryn Frances Heller January 23, 1999 6:00 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 201 South Woodwell Road Dundalk Baltimore W Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F Yrs. 172-24-1737 68 Director June 6, 1930 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 'natural', or hems 23a or 28e-f show Dunda1k Maryland Baltimore 1 Tyas 2XXXV 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? i 21222 United States 201 South Woodwell Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 3 2 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 Years 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Surnama) Pages 1 and 2 should be fill ment of Health and Mental H ant; if Item 27 is marked off 8 Charles Clayton Bloomer Catherine Brugger 19s. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health at Important: if Isan 27 is any injury or other trau Linda Lee Loudermilk/Daughter 119 Church Street Glen Rock, Pennsylvania 17327 20b. Place of Disposition (Name of cematary, crematory or other place) 20a Method of Disposition Data 20c. Location - City or Town, Stete PBurial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery 1/27/1999 Baltimore, Maryland eral Service Lic 22 Nama and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, in shock, or heart leilure. List mot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Batween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical ARTERI CORONARY DISEASE Examiner Examiner IPERTENSIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760, Physician/Medical 50 Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 10 les 2 No 3 Probably 4 Unknown PULMONARY DISEASE Records. þ 24b. Were autopsy lindings available prior to 24a. Wes an eutopsy performed? Completed completion of cause of death? 1□ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 8 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2000 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 | Pending death. 1 ☐ Yas 2 ☐ No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A complately filled in by the fu investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, lerm, street, lectory, office building, etc. (Specify) 4 | Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

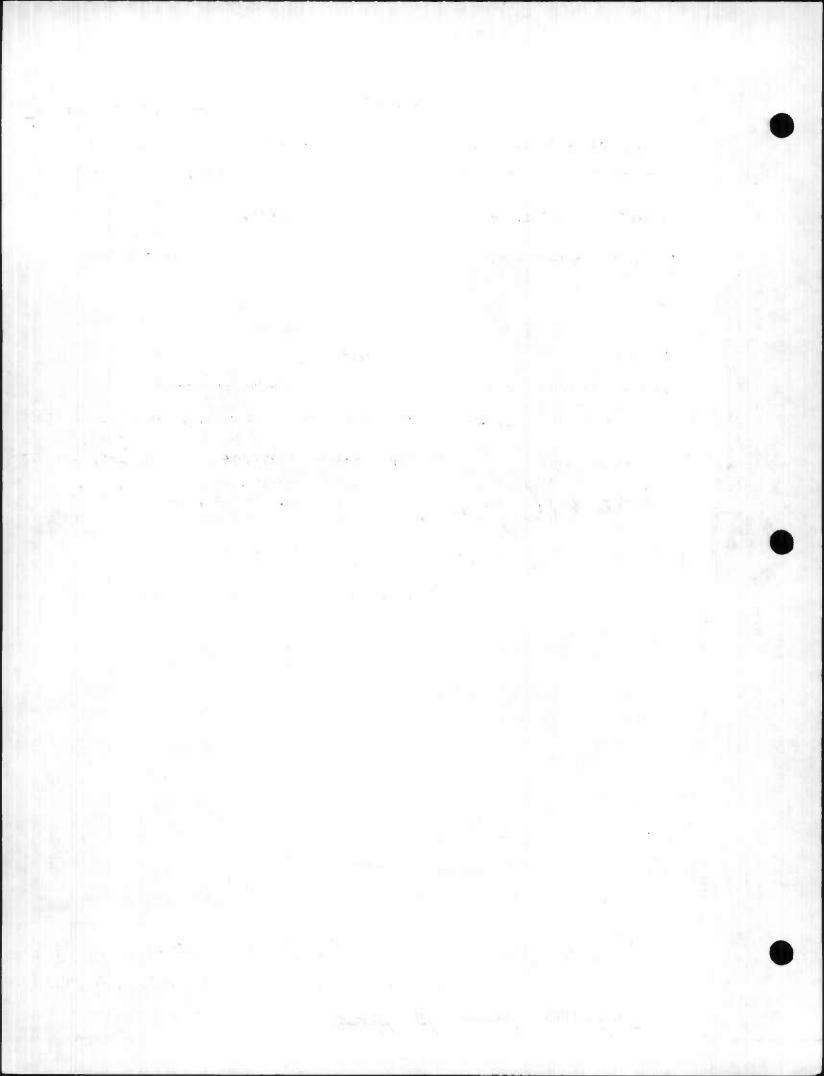
| Cortifying Physician: To the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier odical 29b. Signature 29c. License number 29d. Data signed (Month, Day, Year) MD d cause of death (Item 23a) (Type, Print) BALTIHORE, MD NORTH POINT BLUD OBERT CONNORS MID 1005 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

32, Registrar's Signatura

JAN 2 6 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dey Month **Physician** January 8:45pm Dennis 21, 1999 Russell Hatton /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Towson Baltimore if Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthpiece (Stete or Foreign Country) 6. Sex **Funeral** Deys Min. 1₩ 2□ F Months Hours 59 Director 218-34-0257 Aug 27, 1939 Maryland Usuei Residence of Decedent 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10h. County 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland Baltimore Cockeysville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 505 Warren Road 21030 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian 11. Meritel Stetus Bieck, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or 1 ☐ Yes 2 ☒ No Specify: by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry se filed within 7 sal Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Food Service Banquet Set-Up Person 12 n/a 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) th and Mental I Russell Gladys Dudley Hatton Ε. Burgess 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health an Important: If item 27 is many injury or other Gladys E. McQuade/Mother 505 Warren Road, Cockeysville, MD 21030 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Locetion - City or Town, Stete 20a. Method of Disposition Dete 1 X Buriei 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns.1/25/99 Timonium, Maryland 21. Signifure Funeral Service Licen 22. Neme end Address of Fecility Du W. Clary Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 ed the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximete Intervei Between Onset end Deeth Enter the disease, or complication or heart failure. List only one cause **Physician** Immediate Condition resulting in deeth) /Medical immuno deticiency syndrame acquired Examiner Due to (or es e consequence of): Physician/Medical Examiner attending physician and for use as the bunal-transit certificata be axecuted Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events sesuiting in death) Leet Due to (or es e consequence of) Due to (or es e consequence of): resulting in deeth) Lest The law requires that the death signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of ceuse of death? should l 24e. Was en autopsy performed? Completed has le 2 s certificata ha 1 Yes 2 No 1 Yes 2 No Division of Vital Physician: Be 25. Wes cese referred to medicei 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice Hospitei: 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Aftar this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? Certification: or Attanding 1 Naturel 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piace, and due to the ceuse(s) end menner stated. edicai 29a, Certifier

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Samus Haton

State

29b. Signeture a

30. Neme end eddress of person who complete

Registrar

W. A. Riley 6-BMC 31. Date filed (Month, Dev. Yeer) 32. Registr 's Signeture JAN 26 1999

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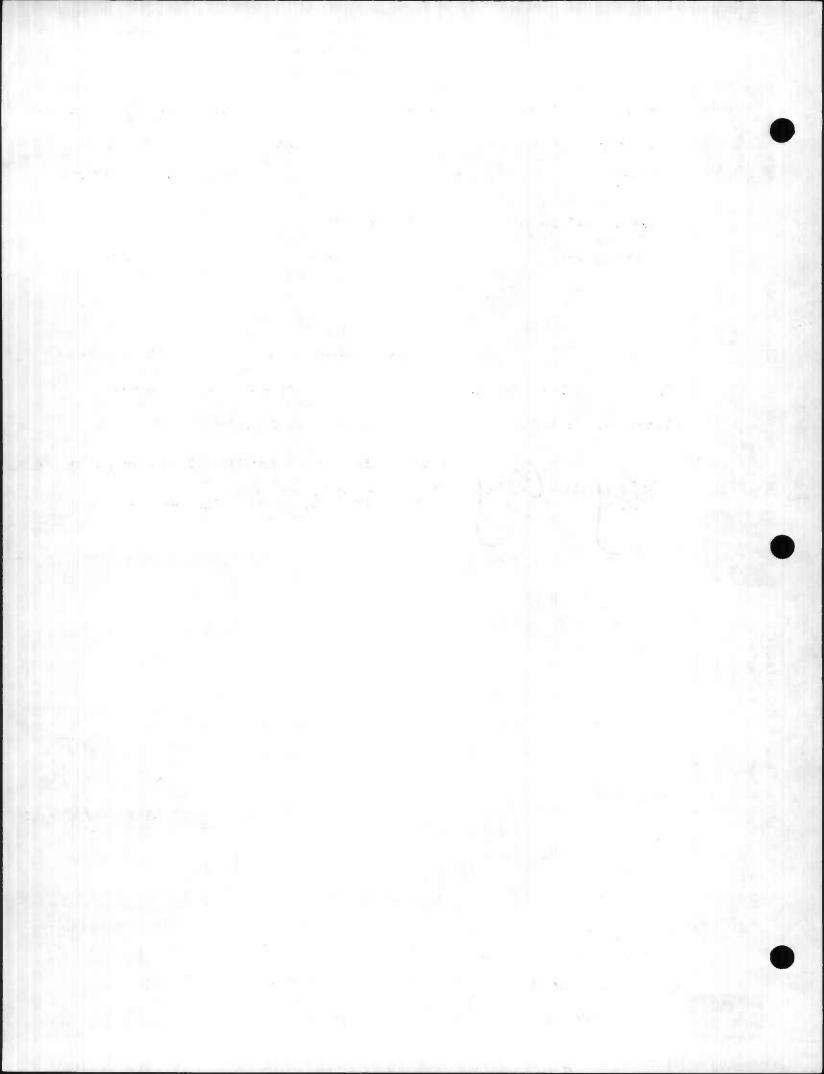
ed cause of deamy tem 23e) (Type, Print)

29c. License number

1)25205

29d. Date signed (Month, Dey, Yeer)

January 22, 1599



Physician

/Medical

Examiner

10a. State

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Funeral

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Funeral

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7 is marked other than "natural", or item traumatic event, tre Medical Expression

or other

Department of Important: If any Injury or page.

Physician

/Medical

Hygiene.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Month Year Alicia Briann Harrington JANUARY 16, 1999 6:15 AM 4a Feclity Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 1 M 20 F 0 6 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes XXNo Rosedale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21237 USA 5202 Redhill Way 12. Was Decedant Evanth US Armed Forces? 1 Yes 2 Tho If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Status N/A Biack, Whita, atc. 1 Naver Married 2 Married **Black** 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Shellish P. Johnson John Robert Harrington 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) G.B.M.C., 6701 N.CHARLES ST., TOWSON, MD. 21204 NIKKI CHILCOAT (STAFF) 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) GREEN MOUNT CREMATORY 1-22 BALTO., MD., 21202 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lhr. 6 min. Smalurile unknown Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy complation of cause of death? 1 Yas 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Naturel 5 Pending 2 Accident

Examiner physician and s the burial-trans 86 980

Division of Vital Records.

or Attending

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after death.

24 hours a Hospital

within 24 ho To the Fune completely f

Examiner Physician/Medical signed t by Completed Be 2 funeral Certification:

25. Was cese referred to medicel exeminer? 1 Yes 2 No 27. Manner of Death

3 Suicide

29a. Certifier

4 Homicide

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Cartifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. Licanse number

29d. Date signed (Month, Dey, Year)

mortilla 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) MONTILLA. M.O. 6217 Harford Rd; Baltimore MD 21214

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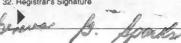
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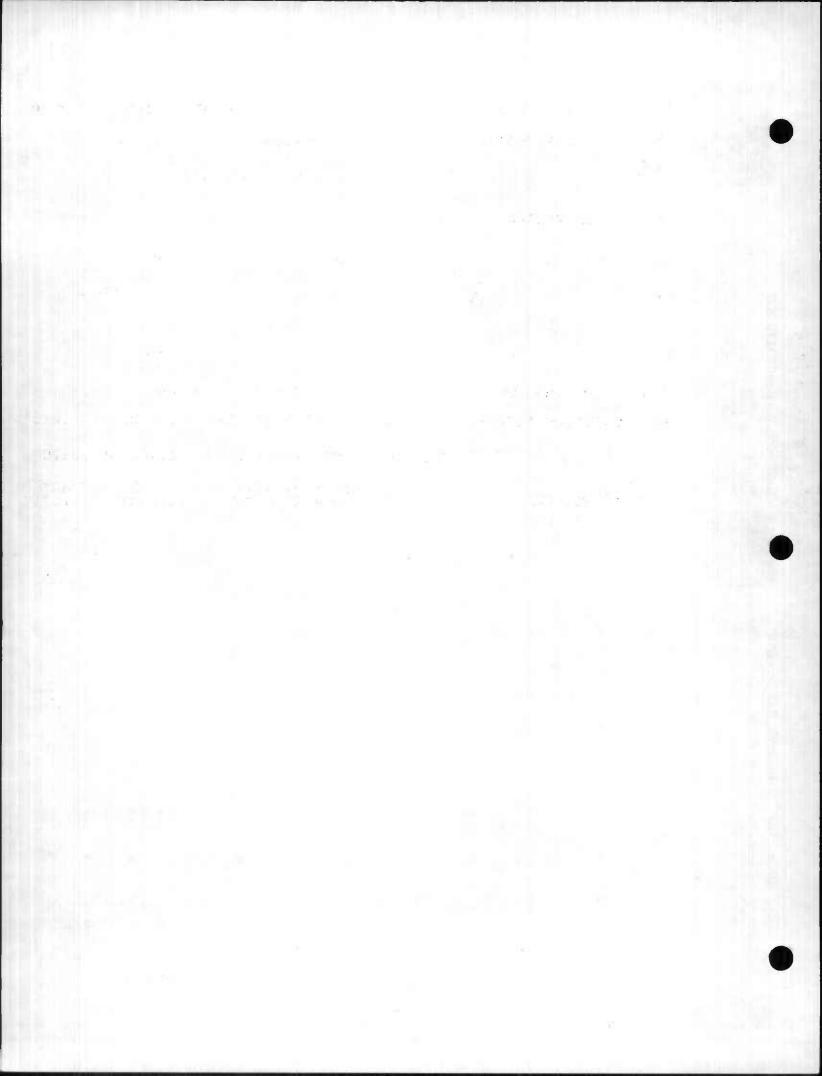
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32. Registrar's Signature

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) Day **Physician** EDWARD PAUL HALES 25, 1999 4c. County of Death 3:46AM January /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore City
Ti Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
Sept 13, 1924 Esther's Place N/A

9. Birthpleca (Stata or Foreign Country) If Undar 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys 1 M 2 □ F Yrs. 74 **Director** New Jersev 155-18-2453 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours effer death with the Marylend Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 ehow any injury or other traumatic event, it is Medical Exprined must be notified at energy. 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 11 Yas 2 No Directo N/A Baltimore City Maryland 10f. Zlp Coda 10g. Citizen of What Country? 10e. Street end Number 21214 USA 2901EStrathmore Avenue Funeral 14. Race - American Indian, Bleck, White, etc. 12. Was Dacedanl Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexicen, Puarto Ricen, etc.) 1 ☐ Yes 2 No If Yes, Giva Yaer or Detes: 1 ☐ Naver Marriad 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) Elementary/Secondary (0-12) College (1-4or 5+) 12th Plant Operator Town Sewer Plant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Elmer Hales 2 Mary White 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 339 Tunbridge Road, Baltimore, Maryland

20b. Plece of Disposition (Name of City or Tow cemetery, cremetory or other plece)

Baltimore, Maryland

20c. Location - City or Tow Elaine Hales-Barlow (Dghtr)
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) St. Catharine's Cemetery 1/29/99 Springlake, NJ 21. Signal Ne, of Funerel Server 22. Nama end Addrass of Fecility Mitchell-Wiedefeld Home, Inc. Dawson Martin D. Martin D. Dawson

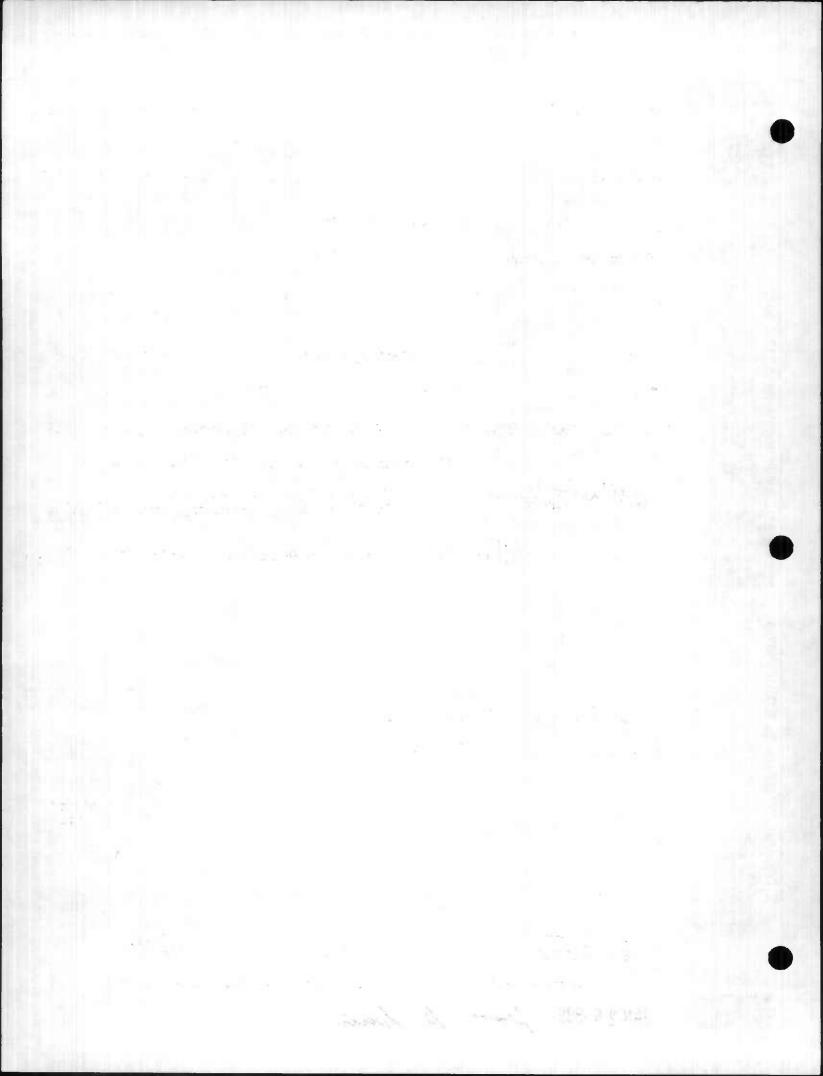
23a. Pert1. Enter the disease, or complications that ceused the death. Do not after the mode or dying, such as cardiac or respiratory grounds. Maryland 21212

Approximate intervel Between conset and Deeth cons **Physiclan** Atherscherotic Cardiovascular Disease /Medical Immediete Ceuse (Final disease or condition resulting in death) Examiner Examiner Saquantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician is the burlet Division of Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical Dua to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown Heart by 24b. Were autopsy findings aveilable prior to 24e. Wes an eutopsy Completed erebrovas culas completion of ceuse of death? is certificate has director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes cesa referred to medicel axeminar? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Wother (Specify) 1 Hospital: Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Living 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 28e. Dete of injury (Month, Dey Year) 28c. Injury et Work? After t or Attending 5 Pending investigation 1 Neturel
2 Accident 1 Tyes 2 No r death. Director: A 6 ☐ Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or Att within 24 hours efter d To the Funeral Direct complately filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and fittle of b 29c. License number 29d. Daje signed (Month, Dey, Year) 30. Name and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Robert J. Vissing, M.D., 4300 North Charles Street, Baltimore, Maryland 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture JAN 2 6 1999

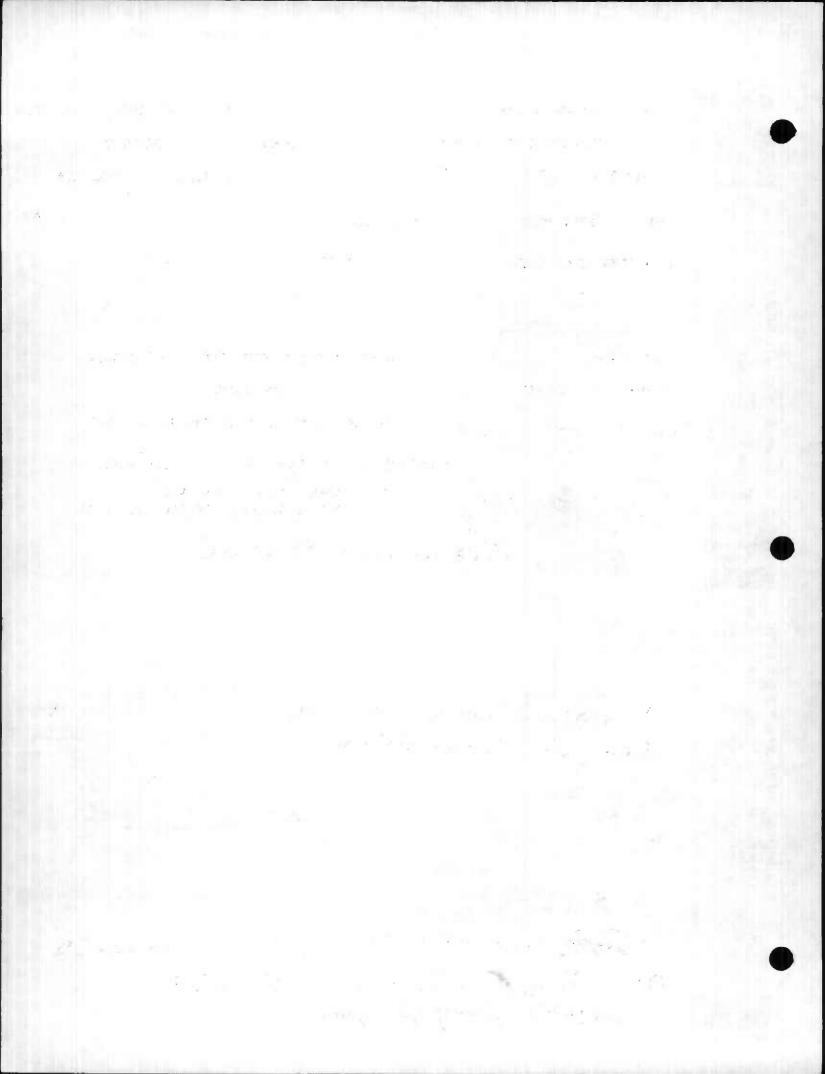
DHMH 16 Rev 6/95

Registrar



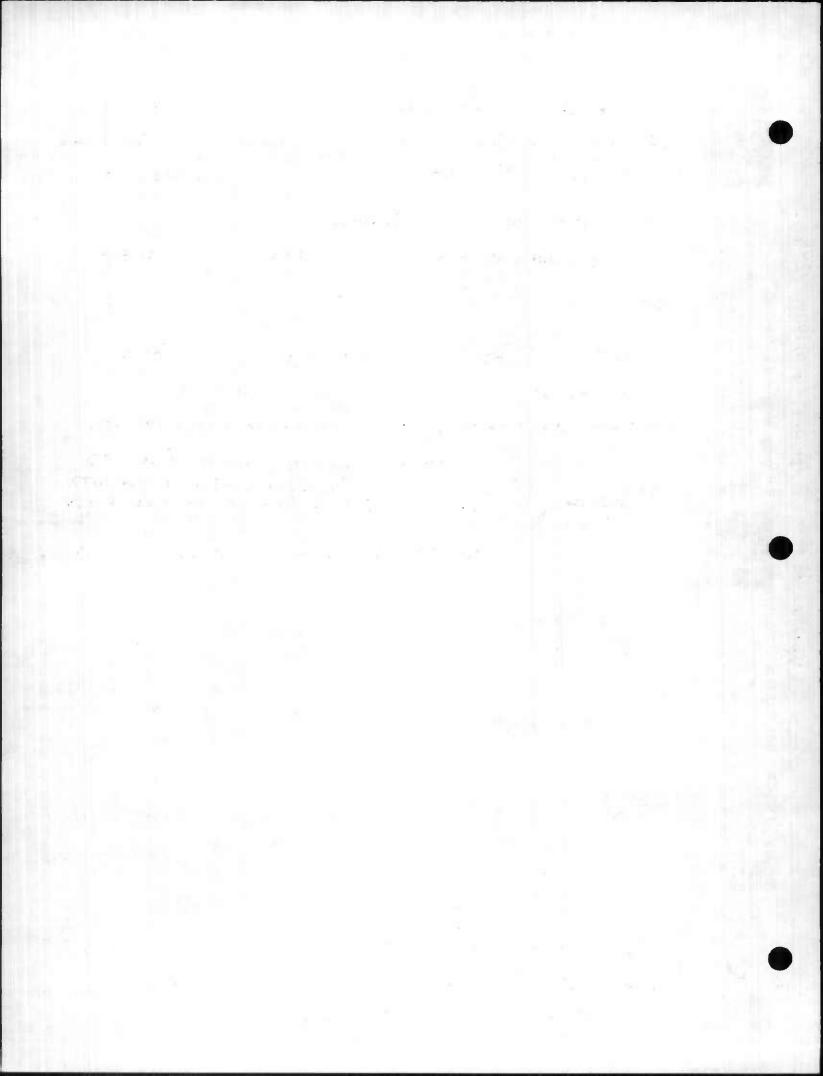
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of	Death	Reg. No.						
Physician	1. Decedent's Nema (First, Middle, Last)		2. Date of De Month	eath 3. Time of Death						
Medical	EDDIE MASON HOLMES		JAN.	21, 1999 7:00 P.M.						
aminer	4a Fecility Nama (If not institution, giva street and number)		4b. City, Town, or Location of Deat	th 4c. County of Deeth						
	GENESIS ELDERCARE LOCH RAVEN		TOWSON	BALTIMORE						
eral ctor	5. Social Security Number 245−18−2751 Usual Residence of Decedent 6. Sex 2	Yrs. If Under 1 Yaar Months Days	If Under 24 Hrs. 8. Data of Bi Hours Min. 08/10							
ad at		Town or Location		10d. Inside City Limits						
	MD BALTIMORE	PARKVILLE		1 ☐ Yes 2 🛣 No						
Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Country?						
ig le	1551	2123	4	USA						
era	1751 GLEN RIDGE ROAD 11. Meritel Status 12. Wes Decedant Ever in U,S		Hispanic Origin? (Specify Yas or No en, Mexican, Puerto Rican, atc.)							
by Funeral	Armed Forcas? 1 Never Married 2 Merried 1 Yes, Give Yes, Give Yeer or Detes:	If Yes, specify Cub	en, Mexican, Puerto Rican, atc.) Specify:	Bleck, White, etc. Specify: WHTTE						
	15. Decedent's Education	16a. Decedent's Usual Occur	pation	16b. Kind of Business/Industry						
Completed	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+)	(Give kind of work done life. DO NOT usa retire	during most of working id)							
E	11th GRADE	FOREMAN BOD	Y & FENDER MECH.	AUTO DEALER						
To Be C	17. Fether's Neme (First, Middle, Last)		18. Mother's Neme (First, Middle							
ToE	EDDIE MASON HOLMES		IDA WINES							
	19e. tnforment's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street	t end Number or Rurel Route Numb	per, City or Town, Steta, Zip Code)						
5	MADIAN D HOLMEC GIER	1751 GLEN R	IDGE ROAD BALTI	MORE, MD 21234						
other		ace of Disposition (Neme of metery, cremetory or other ple	Date	20c. Location - City or Town, Stete						
ō	1 XBuriel 2 Cremation 3 Li Removal from Stete		1 /25 /00	HITHERIDALE MO						
<u> </u>	21. Signature of Funerel Service Licensee	RELAND MEMORIA 22. Nema end Addre	E LIMUX	HILLENDALE, MD						
any Injury or once.	11.11	THE TOUNG	ON EVINEDAT HOME	P.A.						
	of feethir l. flager	8521 LOCH	RAVEN BLVD. TO	DWSON, MD 21286						
	23e. Party. Enter the disease, or complications the Vou and the deeth.	. Do not enter the mode of dy	ng, such es cardiac or respiretory t	Approximate Intervel Between Onsat end Death						
sician	61-1		a search 1	Onsat end beath						
dical niner	Immediate Ceuse (Finel disages or condition Alzheimer Disease									
100	resulting in deeth) e	es e consequence of):								
Examiner	a b									
-tran	Sequentially list conditions, if eny, leading to immadiate									
	Cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or									
e = =	that initiated events resulting in death) Last Due to (or	as e consequance of):								
an	d									
be detached for use the by Physician/M	Part II. Other significant conditions contributing to death but not result	Iting in the underlying cause gi	ven in Pert t. 23b. Did	tobacco use contribute to the cause of death?						
hy	Perpheral Vancule Congeline Heart	ur dines	Me 10	Yes 2 No 3 Probably 4 Unknown						
should be detac	· Callington acusan	5								
	Lungh side and	Fairluse	24a. We	s en eutopsy ormed? 24b. Were eutopsy findings availeble prior to						
ojet	and Eline 12001.			completion of causa of deeth?						
rector, page 2 should Be Completed			10	Yes 20No 1 Yes 2 No						
Ü	25. Wes case referred to medical		26. Plece of Deeth (Check only	· ·						
o Be	exeminer?	ER/Outpetient 3 DOA	har:							
funeral dire	27. Manner of Deeth 28e. Dete of Injury	ER/Outpetient 3L DOA	Nursing Home 5 Hes	how injury occurred						
funeral tion:	1 Natural 5 Panding (Month, Day Year)	Injury Wo	ork?]Yes 2□No							
edical Certification:	3 Sulcida 6 Could not ba	ma, farm, straet, fectory, office		(Street and Number or Rurel Routa Number,						
6 1	4 Homicide determined 286. Plece of Injury - At not building, atc. (Specify,	na, iaini, siraet, iectory, office	City or To	own, Stete)						
S S										
completely filled in by the Medical Certifical	29a. Certifier 1 Cartifying Physician: To the best of my know 2 Medical Examtner: On the besis of examinetic									
8	one) end menner stated.									
2	29b. Signeture and title of certifier Zicol Mi	(for MD 29c. Licen	se number	29d. Data signed (Month, Dey, Year)						
	a della constant	12	41901	1-55-30						
	30. Name and address of person who completed cause of deeth (item	23e) (Type, Print)	111 0 -	. 1						
	3001 C. Warthian Ykul.	L Kaltima	0 Md. 212	14						
State	31. Dete filed (Month, Dey, Yeer) 32. Registrar's Signal	une /		,						
nietrar	JAN 2 6 1999	J. D. Moark	2/							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) HOPM **Physician** HERRING JANUARY ENORE K. 25,1999 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPICE CENTER (7: LLCREST Towson If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Undar 1 Yaar 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number **Funeral** Days 1 M 2 NF Months 95 Yrs. 3, 1903 Director 215 - 10 - 1389 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a Stata 10b. County 10c. City, Town or Location 1 Yas 2 No PARKVILLE MD BALTIMORE Directo 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? I is marked other than "natural", or items 23a or traumatic avent, the Medical Examiner must be a 217-34 U.S.A BAVERN WOOD AVE 2712 Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yas 2 ☑ No It Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married 1 Yas 2 No Specify: Specify: WhITE April 225, 1999 by 3 Widowed 4 □ Divorcad Completed Decedant's Usual Occupation
 (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry filed within 7 Hygiena. Elementery/Secondery (0-12) College (1-4or 5+) 10 SECRETERY NIN 18. Mothar's Nema (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) and Mentel UNKNOWN UNKNOWN 19b. Mailing Addrass (Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health itam 27 A SCH EMEIER 2706 BAUEANWOOD AVE BALTO NO 21234 FRANKLIN 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Important: If it any injury or o 1 Burial 2 Cramation 3 Ramoval from Stata 1/26/99 BACTO. MD 4 ☐ Donation 5 ☐ Other (Specify) Greenmount cemeteren 22. Nama and Addrass of Facility Hartley Miller Funeral Home CHTD. 21. Signature of Funaral Sarvice Licansee Lenore Herring BAUD ND 21234 7527 Halford RD Part Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** acute throm botic stoke tmmediata Causa (Final disaese or condition rasulting in death) /Medical days Examiner Examine physician and the bunal-transit Sequentielly list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that Initiated avants rasulting In death) Last Due to (or es a consequença ot): Physician/Medical Dua to (or as a consaquanca of): 23b. Did tobacco use contributa to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No by Division of Vital Records. 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? i certificata has b 1 ☐ Yes 2 X No 1 Yas 2 No or Attending Physician: 25. Was case referred to medical axeminar? 28. Place of Death (Chack only one) Be Other: 4 Nursing Homa 5 Rasidanca 8 Other (Specify) 10 Spice 1 Yes 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27, Menner of Deeth 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Data of tnjury (Month, Dev Year) 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No invastigation 2 Accident after death Director: / 6 Could not be determined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 4 Homicide within 24 hours after To the Funeral Dire completely filled in b † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar To the Within 2 To the 29d. Data signed (Month, Day, Year) 29c. Licansa number mo rup ed causa ot daath (frem 23e) (Type, Print) 6701 N. Charles St 31. Data tiled (Month, Day, Year) 32. Registrer's Signatura JAN26 Registrar **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 24, 1999 4:20PM EDWARD A. HOLMES Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Nama (If not institution, give street and number) Examiner Towson Baltimore Gilchrist Center 6. Sex 14 M 2 F If Undar 1 Year | If Under 24 Hrs. Birthpleca (Stete or Foreign Country) 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours 78 Yrs MD Dec. 31, 1920 **Director** 219-05-1985 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Johnarday,1999 e 4-9pm 1 Yes 2 No Directo MD Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Coda r than "netural", or items 23a or the Medical Esaminer must be r U.S.A. 21117 5 Pleasant Ridge Rd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 1 1 Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Naver Married 2 Married 1 ☐ Yes 2 ☒ No Spacify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Busineas/Industry 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) Letter Carrier Post Office 12 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fathar's Name (First, Middla, Last) should be and Mental is marked Arlene Goetzendonner Edward A. Holmes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8007 Melody Lane, Baltimore, MD Health Hem 27 Jeanne R. Berger Daughter 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donetion 5 Other (Specify) Carroll Cremation 1/27/99 Hampstead, MD 21. Signajoje of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, MD 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 5 month Examiner Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last pue Due to (or es a consequence of) physician the burie Box 68760. certificate be Physician/Medical Dua to (or as a consaguanca of). 98 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o the signed by t 3 Probably 4 Unknown 1 Yee 2 No Division of Vital Records, P. by law requires 24b. Were autopsy findings available prior to 24a. Was en eutopsy Completed peen completion of cause of death? The 1 Yas 2 No certificate Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Lo 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how Injury occurred 27. Manner of Deeth 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After 1 Certification: or Attending 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No deeth. I Director: A 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Exports effect
 Funeral Direct
 Hetely filled in b efter Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 25205 30. Name end address of person who completed cause of deeth (frem 23a) (Type, Print) W. M. R.lay Bostr. and ZIZUY Grown N. Charles St 6251 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State

Registrar

CLWORD Halmes

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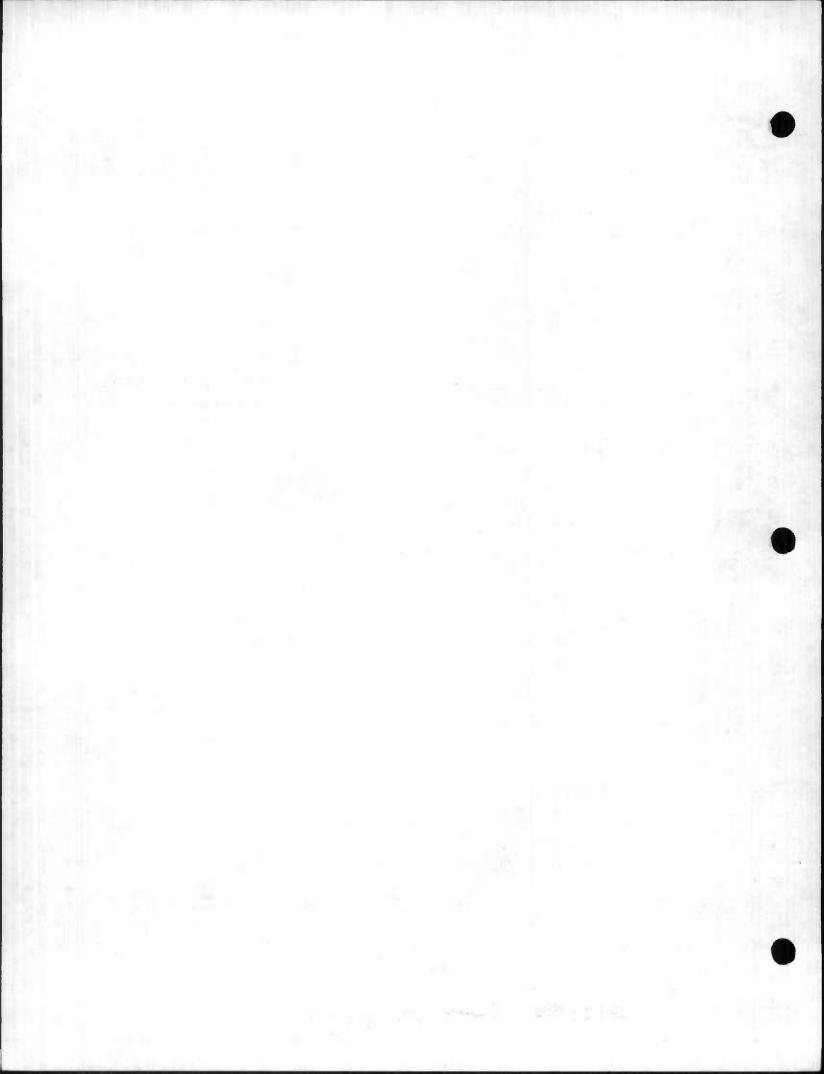
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State of Maryland / Department of Health and Mental Hygiene 99 0 736

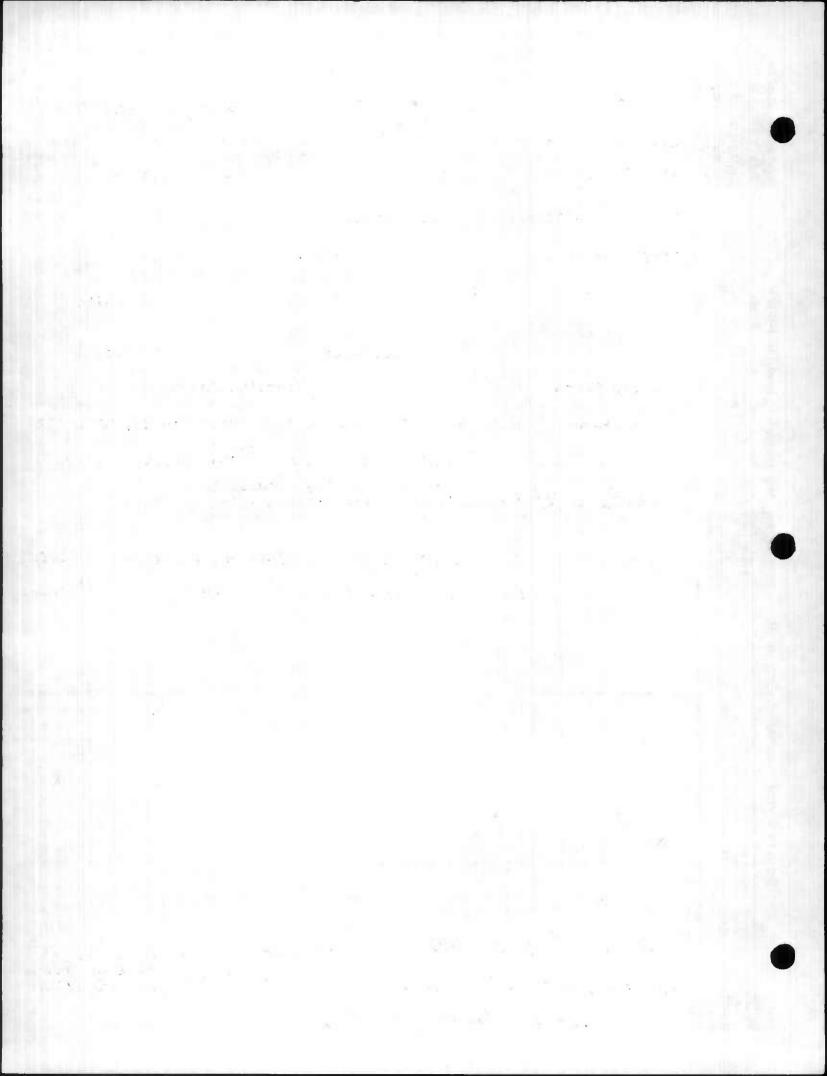
Certificate of Death

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Physician // Lodion		e (First, Middle, La		red Hop	okins					2. Date of De Month Januar	Day	Year	3. Time of Death 6:00 A.M.		
/Medica Examine	4a Facility Name (/	4a Facility Name (If not institution, give street and number) 2822 Vermont Avenue						4b. City, To		ocation of Deat	h 4c. County				
Funeral Director	5. Social Security N 216 05		Sex 1□M 2⊠F	last birthday) Yrs.	Months [ear If Under 24 lys Hours I		8. Data of Bir (Month, Da March	irth 9. Birthplace Country 1		ce (State or Foreign yland			
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off the Ma	10s. Street and Nur	nber				10f. Zip	p Code				10g. Citizen of V	What Country	n		
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-0020 hours after death v wraff, or items 23s al Examinar must	3√ Widowed	ed 2 Married	12. Was Dece Armed Fo 1 Yes If Yes, Gin Year or D	200 No				lispanic Or an, Mexica Specify:		ecify Yas or No Rican, atc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0020 42 should be filed within 72 hours at the and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam To Re Commission hour	(Spec	15. Decedent's E ify only highest grandary (0-12)	ducation ade completed) College (1	-4or 5+)	16a. Dece (Give lifa.	kind of work done during most of working DO NOT use retired)						of Business/Industry			
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yland ouid be ill Mental H write even		17. Father's Name (First, Middle, Last) James M. Co							Ма	Name (First, Middle, Maiden Surname) Madora Eugenia Zimmer					
		se Hopkin			2822	Verm	ont	Avenu		Baltimo	ore, Mar	yland	21227		
altimore, mit. Pages 1 at partment of Hea portent: If Hem. y Injury or other		osition Cremation 3 [5 Other (Special		State	Place of Dispo cemetary, cre rraine	matory or o	other pla		, 1	Data ./16/99	20c. Location - Baltim		faryland		
Ball permit bepart import any in ans in	21. Signature of Fu	111 47 - 1						d Address of Facility Gonce Funeral Home P.A. tchie Highway Baltimore, Md. 21225							
Physician /Medical Examiner		nditions, mediata nying niury	a. A		or as a consecutive or a c										
OX 687 certificate inding phys use as the	resulting in death) L		d	Due to (d	or as a consec	uence of):									
s, P.O. Be to that the death good by the attent be detached for by Physician	Part II. Other signifi	cant conditions of	eth but not res	sulting in the u	nderlying o	ceuse gi	ven in Part	l.	23b. Did	he cause of death?					
Pording Peen a should at a d										24a. Was	an autopsy ormed?	availa	a autopsy findings able prior to oletion of cause ath?		
										10	Yas 20No	101	Yes 2□ No		
Of Vital I Physician: The this carificate ral director, page Co.: To Ba Co.	examiner?		Hospital: 1 🗆 I	npatient 2] ER/Outpatier	nt 3 DC	OH OH	hac		th (Check only one 5 Alesi	eck only one) Mesidence 6 Other (Specify)				
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To the Hospital within 24 hours To the Funeral completely filled		2[] Medical Exam	niner: On the ba	sis of axamina ner stated.	ition and/or in	vestigation	i, in my o	opinion, dea	ath occur	red at tha time,	data and place,	and due to th	ne cause(s)		
To with To who T	1A	SCEE	er /	PI	de	-	C. Licens	O 14	198	}	Janua		5,1999		
	30. Name and addre		c hoice	- Far		Print)	30.	B	1150	imore	am s	515.	38		
State	31. Data filed (Mont	Day, Year) 19	99 32. P	gistrar's Signa	ature L	1									



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Mercialan		ecedent'a Nam	e (First, Middl	le, Last)		-						2. Date of Dei Month	ath Day	Yaar	3. Time of D
hysician /Medical		<u>_</u>	Clitt	2	1	Saa	CS					Januar		1999	9:10
Examiner		acility Name (I			eet and numb	er)			41	b. City, Tow	n, or Loc	cation of Death	4c. County	of Deeth	
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uneral rector	2	ocial Sacurity N 15-28-	-4938	6. Sex 1 □ M	7.	Age (In yrs.	last birthday) 5 Yrs.	If Undar Months		If Undar 2	Min.	8. Date of Bird (Month, Da Feb 10		9. Birthp Cour MD	olece (State or otry)
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or 28a-f	111			. CIMC	71.6	1	JI C 11C	_					40- 011	140-140-1	
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by by	3	Marital Status I □ Naver Marri B □ Widowed		rried	. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	is? ☑ No			dent of Hiscify Cubar 2XNo		n? (Spe Puarto F	cify Yas or No Rican, atc.)	- 14. Rad Bia Specil	ce - Americ ck, White,	
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or other		Method of Disp	Cramation		noval from Sta	110	Place of Dispos cemetery, crem	sition (Ner natory or o	me of other place	9)	Ja	Date an 25	20c. Location	- City or To	own, State
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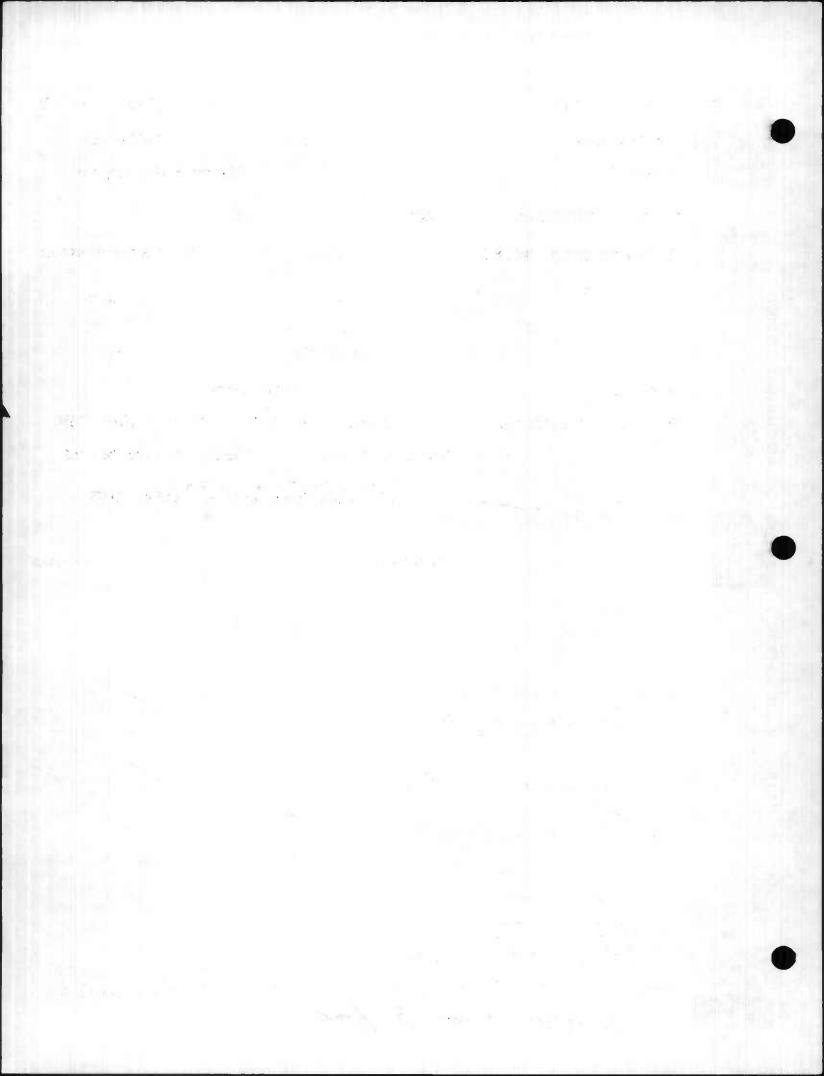


Registrar
DHMH 16 Ray 6/95

31. Date fited (Month, Day, Year)

32. Registrar's Signeture

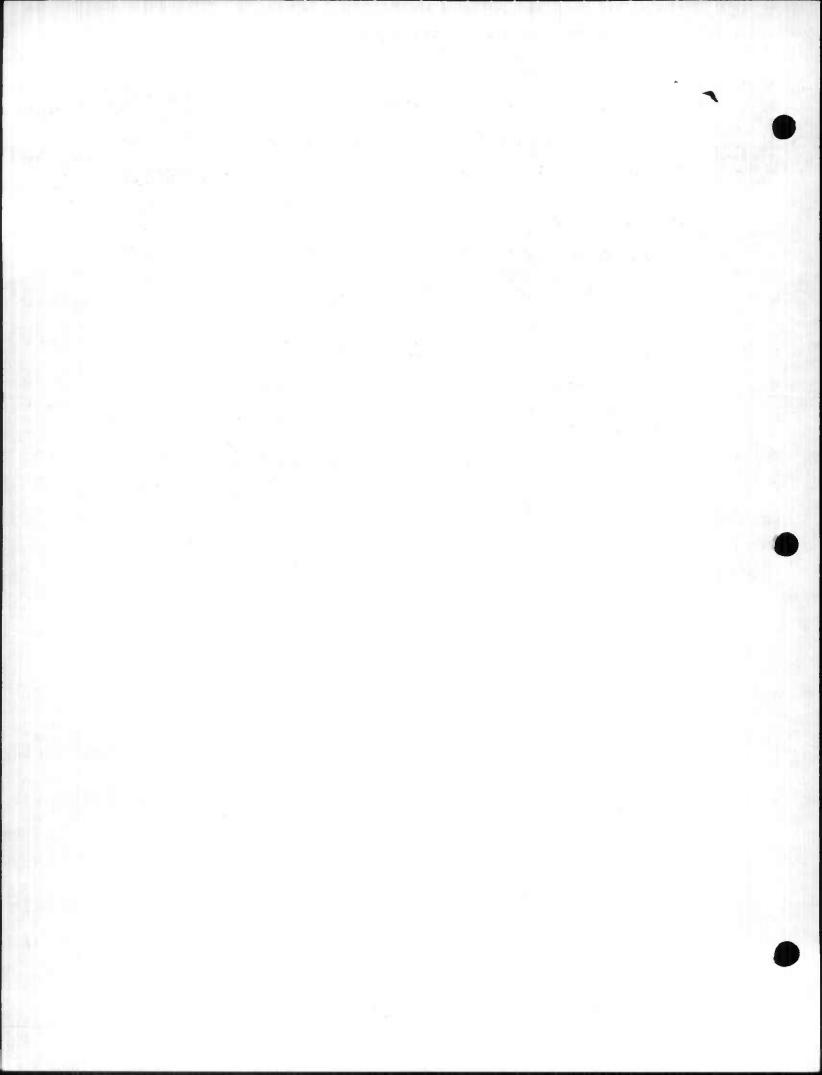
Division of Vital Records, P.O. Box 68760,



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		1 Decedent's Name (First, Middle, Las	(t)		Certificate of	Death	0.00	Reg. No.		2 7- 15	
Physicia /Medic		LAWRENCE	M.		ISON		2. Date of De Month	19 ^{ay}	4 9	3. Time of Death	
Examin	er		street and number		CENTER	BALL	Location of Deet	4c. County	of Death		
Funeral Director		5. Social Security Number 2/4-/8-37// Usual Residence of Decedent	9x 7. Ag	ge (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. Month, De	th ly, Year) 1, 1913		ece (State or Foreign ry) Y/1990	
show		10a. State 10b. County		10c. City, Town	or Location		•		10	d. Inside City Limits	
28a-f shon	ctor	Haryloso M.	h	A	BAITIMORE					10 vos 2□No	
8 8	Funeral Director	10e. Street and Number 4919 HERRIN	g Run I	Drive	10f. Zip Code	1214		10g. Citizen of V		ry?	
or its	by Fune	11. Marital Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1.27 Yes 2 I If Yes, Give Yeer or Dates:	Ever in U,S.	13. Was Decedent of H If Yes, specify Cube	lispanic Origin? (en, Mexican, Pue Specify:	Specify Yes or No orto Rican, etc.)		e - America ck, White, e	itc.	
"natural", edical Ex	ted	15. Decedent's Ed	ucation	16a.	Decedent's Usual Occup	ation		16b. Kind of Br			
al Hygiena.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or		(Give kind of work done life. DO NOT use retired	during most of wi	orking			USINESS	
	To Be	17. Fether's Name (First, Middle, Last) FRANK SUHNS	on			18. Mother's Na	ame (First, Middle		10)		
neatin and em 27 is me other traum		19e. Informant's Name/Reletionship (1) ALICE SUN NOSM	ype, Print) WIFE	196.	Malling Address (Street 19 HCRP	and Number or F	Rural Route Numb	er, City or Town, BALH			
nt: If item		20a. Method of Disposition 1 Burial 2 Cremetion 3 C 4 Donation 5 Other (Specify			Disposition (Name of crematory or other place) Alley Mo		Daje _33	20c Location -		wn, State W, Ald	
Important: I any Injury o		21. Signature of Funeral Service Licen-	see ~(7)	DOINI	22. Name and Addre	ss of Facility (Rem	- HARR			
ysiclan		23a. Pert1. Enter the disease, or composhock, or heart failure. List only of	lications that caused one cause on each li	d the death. Do n	ot enter the mode of dyin	g, such es cardia	ac or respiratory e	rrest,	I	Approximate Intervel Between Onset and Death	
Medical caminer		Immediate Cause (Finel disease or condition resulting in death)	a My	Due to (or as a c	dial 9 /	nfar	ction	1			
and I-transit	Examiner	Sequentially list conditions, if any, leading to Immediate	b	Due to (or as a c	onsequence of):						
g physicia as tha bur	by Physician/Medical	Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of):									
attanding I				Id tobacco use contribute to the cause of death's							
by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to th			
ata has been sign page 2 should be							24e. Was	an autopsy rmed?	con	re autopsy findings leble prior to apletion of cause eath?	
							10	res 250No	10	Yes 200No	
	o Be	25. Was case referred to medical examiner?	Hospital:	AEI EDIO.	Oth	or:	eath (Check only				
T To		1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursit 2. Reference of Deeth 1 Netural 5 Pending Investigation 2 Accident Netural 5 Pending Investigation 1 No Notation 1 No						5 Residence 6 Other (Specify) Describe how Injury occurred			
I Director. ed in by tha	Certification:	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)								Route Number,	
	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	alclan: To the best of ner: On the basis of and menner sta	examination end	death occurred at the tim or investigation, in my o	ne, date end plac pinion, death occ	e, and due to the surred et the time,	ceuse(s) and ma date and place, a	nner as ste	oted. the cause(s)	
Total	X	29b. Signeture and title of certifier	K. T	npee		3066	,	29d. Date signed Januar	1 2	200 1999	
REA		30. Name end address of person who co	ompleted ceuse of d	eath (Item 23a) (1	Talling	TRO A	JR19	URAA 239.	EN	1	
State Registra		31. Date filed (Month, Day, Year)	32 Registr	er's Signature	locate	,					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Q Certificate of Death Rea No

3. Time of Death

9. Birthplece (State or Foreign Country)

10d. Inside City Limits 1 Yas 2 Dio

Approximete intervel Between Onsat and Death

6:00 PM

2. Dete of Death 1. Decedent's Name (First, Middle, Last) TANVARY **Physician** FOHNSON SAMBILLIEMAE /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, giva street end number) 4c. County of Death **Examiner** RAMALLSTOWN KALTIMORE: CENTER. HOSPITAL MORTHWEST 5. Social Sacurity Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey 16, 1916)

Jan 16, 1916 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min 1 M XXX 83 Yrs. Director 229-26-3570 Usual Residence of Decedent the Merylend r 28a-f ahow 10e State 10b. County 10c. City. Town or Location MD Baltimore Owings Mills Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Peges 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
Intel filem 27 is marked other than "natural", or items 23a or "sury or other traumatic event, i'm Medical Examina man be on any or other traumatic event, i'm Medical Examina man be o 21117 151 Wilgate Rd. USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 225 Ko If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Orlgin? (Specify Yas or No-If Yas, specify Cuben, Mexicen, Puerto Ricen, atc.) 14. Race - American Indien, 11. Meritel Stetus Bleck, White, etc. 1 ☐ Naver Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 → O Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of wark done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Home Maker 6th 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Willie Searl Edna **Blue** 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Lillian Perry/ 151 Wilgate Rd. Owings Mills, MD 21117 20b. Place of Disposition (Neme of cematery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete King Grant State 2 Cremation 3 Removal from State permit. Pege Department of Important: If any Injury or once. 1/29 Baltimore, MD 4 ☐ Dogetion 5 ☐ Other (Specify) Mt. Zion Cemetery Signature of Funeral Service Licansas 22. Name end Address of Fecility

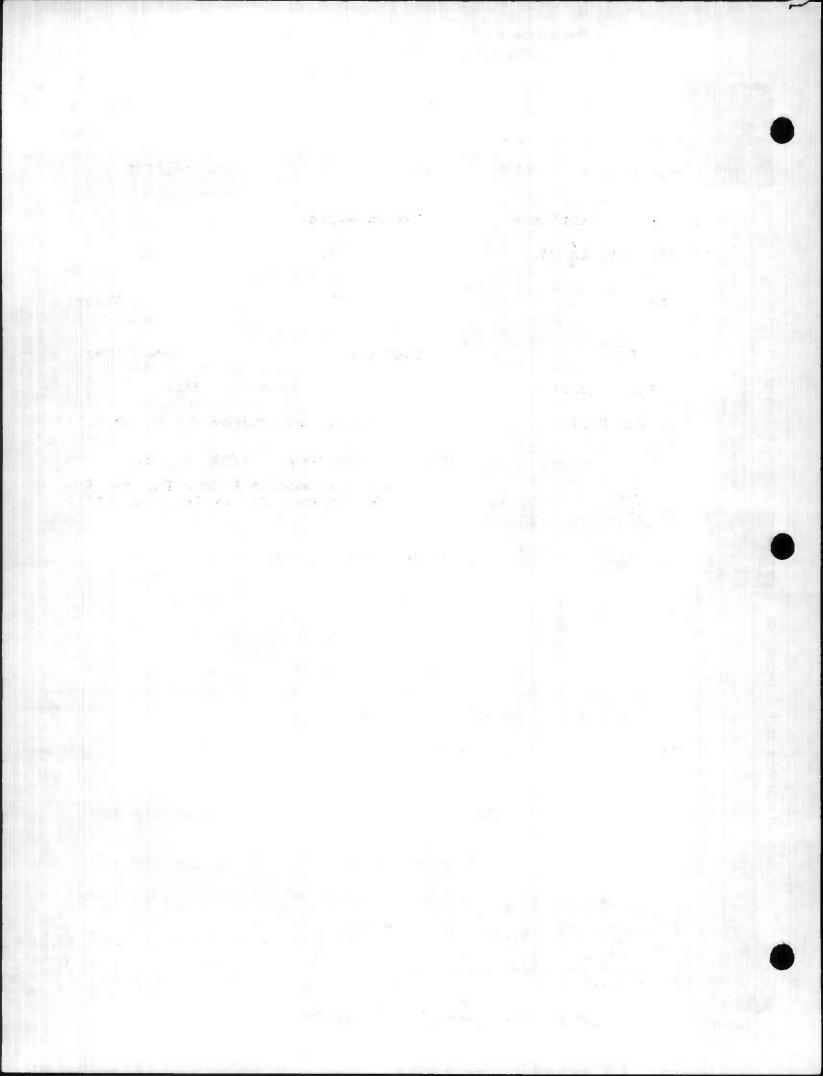
James A. Morton & Sons Funeral Home • 1701 Laurens St. Balto., MD Enler tha disease, or complications that caused tha death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Physician Immediete Ceuse (Final diseesa or condition resulting in death) /Medical RECTAL CARCINOMA WITH METASTASES TO Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or es e consequence of): physician s the bur Division of Vital Records, P.O. Box 68760 Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): 80 esn signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY 32A3210 þ 24a. Wes en eutopsy Completed DIABETES MELLITUS certificate hes t lirector, page 2 s 1 ☐ Yes 2 No 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 70 1 Yes 2 No 1 patient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28b. Time of Certification: 28a. Dete of Injury (Month, Dev Year) 28c. Injury at Work? 5 Pending or Attending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

24b. Were eutopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 24 hours after des Funeral Directo pletely filled in by th 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted.

Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner steted. Medical To the Hosp within 24 ho To the Fune completely f (Check only one) PHYSICIAN 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. Licensa number HOUSE TANVARY 24TH 1999 Janon D42727. FOXFORD STREAM RP 3745 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) BALTIMORS MR 21236 HARISH -HVUERAHALLI m 31. Data filed (Month, Dey, Year) 32. Registra s Signeture

Registrar

JAN 26 1999



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State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Maria Janiak 5 AM 1999 January 23 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 943 Old Annapolis Neck Road Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 F Months 579-42-7265 79 Director April 9,1919 Poland Usuel Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Director Anne Arundel Annapolis 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 traumetic event, the Medical Examiner must be USA Norma 23a 943 Old Annapolis Neck Road 21403 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes, 2 No H Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Maritel Stetus Bleck, White, etc. 72 hours after 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White by 3 XWidowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filled within 72. Department of Health and Mental Hygiene important: if hern 27 is meritad other than "nafus any injury or other traumatic event. 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Men's Tailor Clothing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marchin Herda Marianna Btashauk 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Irene Janiak Park - Daughter 3265 Chrisland Drive, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremetion 3 ☐ Removel from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 01/27 Brentwood, MD 21. Signature of Funeral Septice Licensed 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Pent1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Due to (or as e consequence Physician/Medical Examiner and certificata be axecuted attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760 Due to (or es a consequence of) The law requires that the death P.O. the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 TUnknown Division of Vitai Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has i page 1 Yes 2€No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of cortifies 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 104 Ridgely 31. Date filed (Month, Day, Year) Barbara Furlow, MD 32. Registrar's Signature

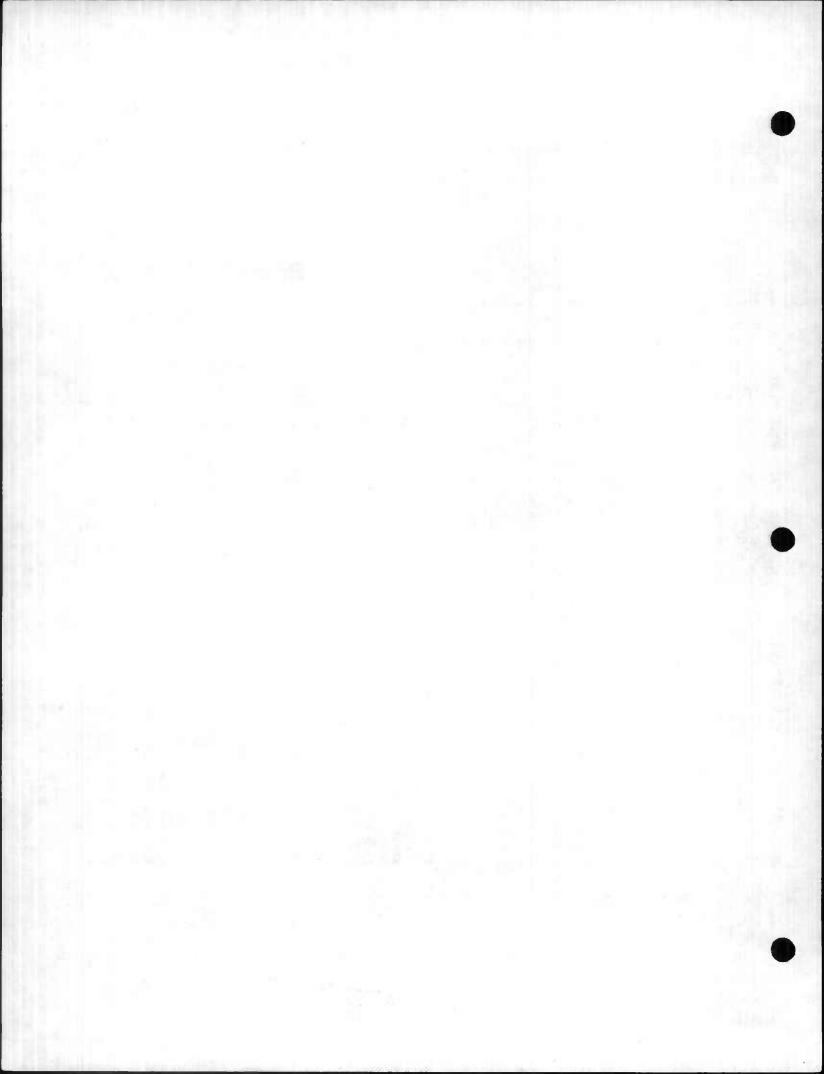
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1999

JAN 26



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Deeth **Physician** Month Yaa 4a. Facility Nama (If not institution, giva street and number) 22 QQ 4c. County of Death 4b. City, Town, or Location of Death 2.58 PM /Medical **Examiner** Carroll County General Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Dey, Year) | NOV . 27, 10 6. Sax 1 M 2 □ F 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Yrs. Director MD 218-34-0263 60 Usual Rasidanca of Dacedant with the Maryland 10a. Stata 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours eiter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, "it we do all Examine man be notified as 10d. Insida City Limits Director 1 Yas 2 No Baltimore Reisterstown 10e Street and Number 10f. Zip Coda 10g. Citizen of What Counfry? 906 Shirley Manor Rd. 21136 U.S.A. Funeral 12. Was Dacedanf Evar in U,S. Armed Forcas? 1 N Yas 2 No If Yas, Giva 14. Raca - Amarican Indian, Biack, Whita, atc. 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: þ 3 Widowad 4 Divorced Yaar or Datas: White Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 8 Truck Driver MD State Highway 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be William M. Jones Gladys R. Pritt 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Barbara J. Jones Wife 906 Shirley Manor Rd., Reisterstown, MD 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1\(\begin{align*} \text{Burial} & 2 \quad \text{Cramation} & 3 \quad \text{Ramoval from State} \\ 4 \quad \text{Donation} & 5 \quad \text{Othar} \(\text{Spacify} \) Evergreen Memorial Gardens 1/26/99 Finksburg, MD 11824 Reisterstown Rd. 21. Signatura of Funarai Sarvice Dicensi 22. Nama and Addrass of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, such, or heart failure. List only one cause on each line. Reisterstown, MD Approximata Intervel Batween Onsat and Death **Physician** /Medical · CARDIDGEN Immadiata Causa (Final MIN disaasa or condition resulting in daath) **Examiner** Examiner the bunal-transit Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Diseese or injury that initieted avants rasulting in daath) Last and P.O. Box 68760. Physician/Medical Dua to (or as e consequança of) signed by the aid be detached if Part II. Other significant conditions confributing to death buf not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes. 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to complation of causa of daath? Be Completed 24a. Was an autopsy performed? 25. Wes casa refarred to medicel axaminar? Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 26. Plece of Death (Check only one) Hospitai: 1 Inpatient 2 ER/Outpatienf 3 DOA 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Medical Certification: To 27. Mapnar of Death 28e. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 Yes 2 No 2 Accident 3 Suiclda 6 Could not be detarmined 28e. Piece of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 | Homicida Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner se stated.

Z Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner states. 29a. Cartifian 29b. Signatura and fitla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Neme and add ss of pen completed cause of daath (Item 23a) (Type, Print)

Registrar

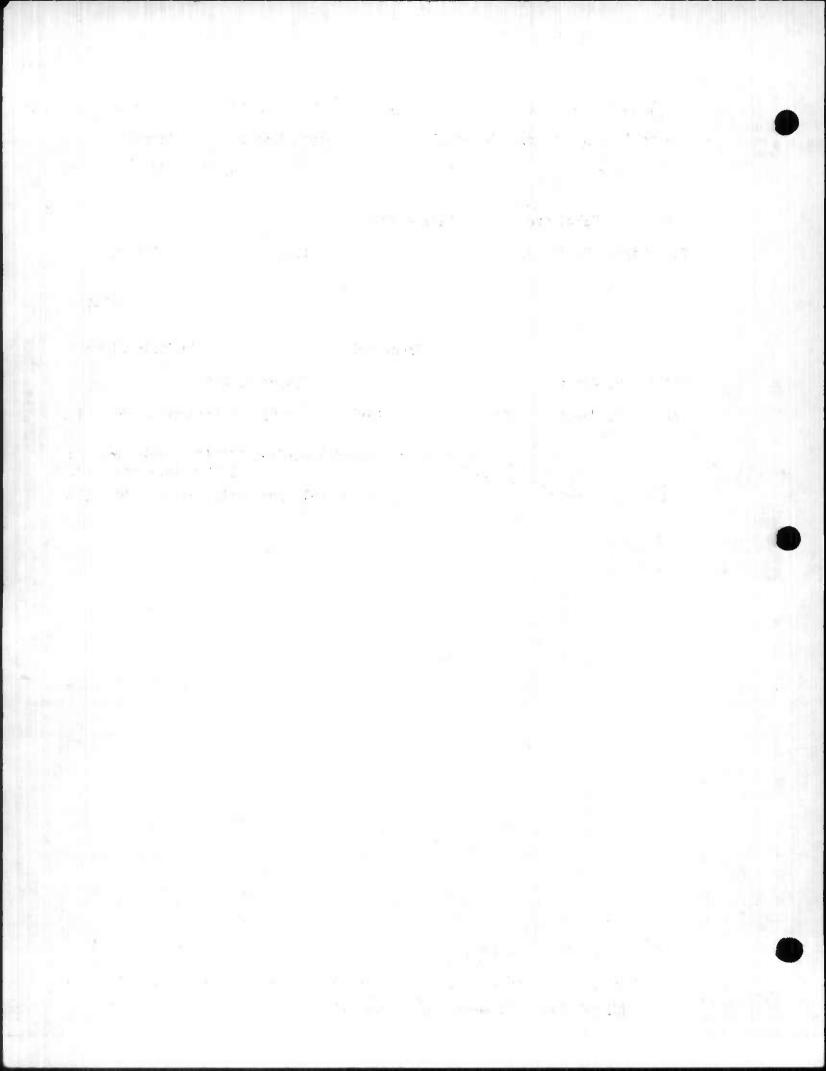
State

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32 Registrar's Signatura

31. Data filad (Month, Day, Year)

JAN 2 6 1999



Registrar

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Dennis Chute M.D.

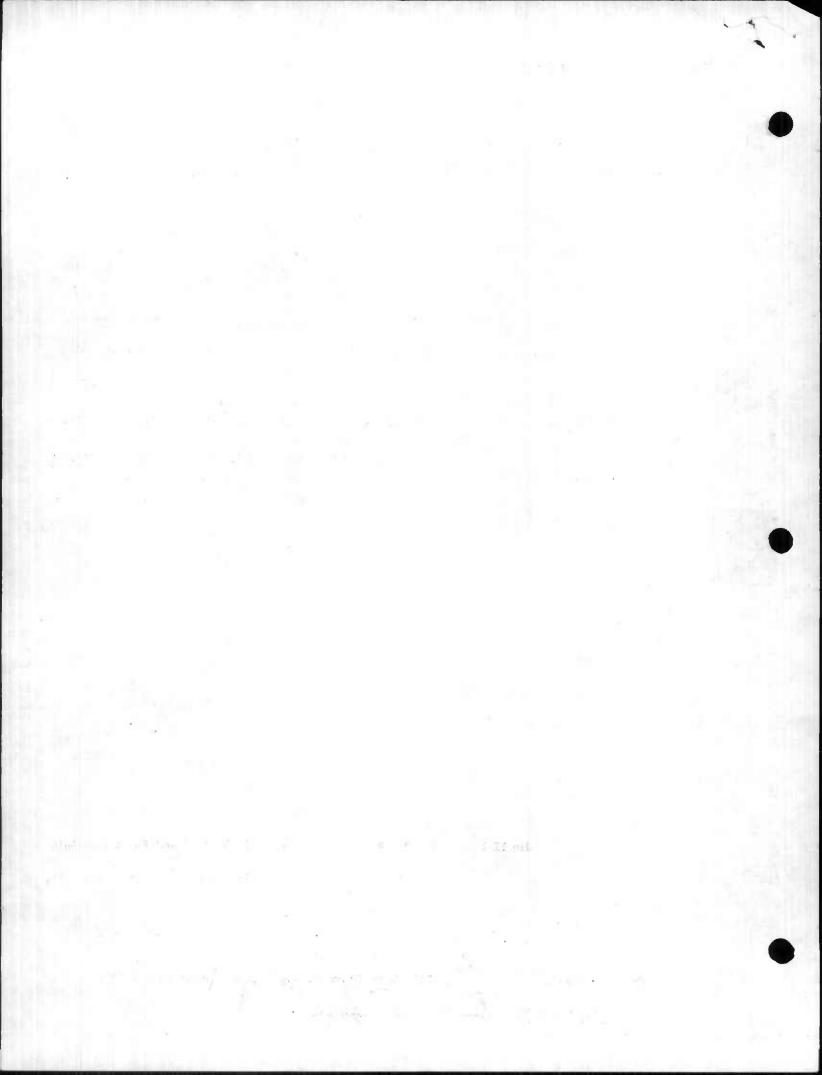
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31. Dete filed (Month, Dey, Year)

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32. Registrer's Signeture

111 Penn Street, Baltimore, Maryland 21201

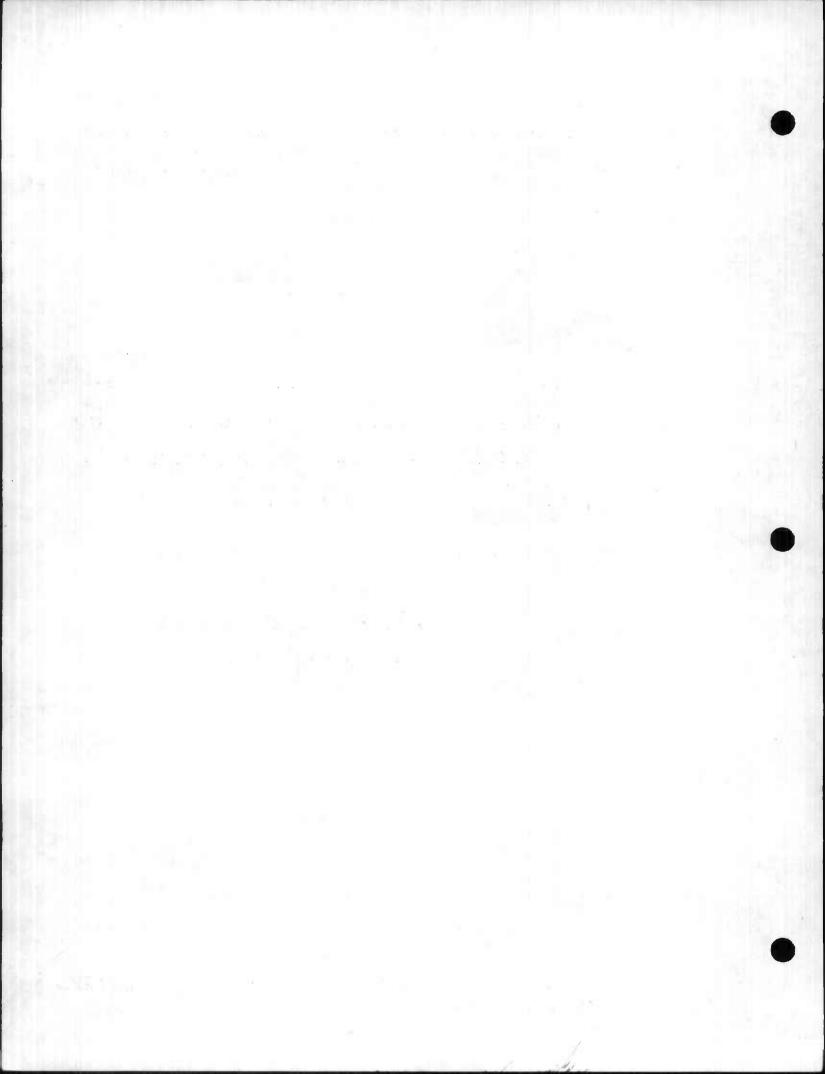


Jahmer, Arma

Medical Examiner As Facility Name (if not institution, give street and number) As City, Town, or Location of Death As County of GREATER BALTIMORE MEDICAL CENTER TOWSON BALTI TOWSON	Birthplaca (State or Foreign Country) ATYLAND 10d. Inside City Limits 1 Yes 2 No at Country? A. American Indian, White, etc. White				
Ab City, Town, or Location of Death Ab City, Town, or Location Balary Balar	Death IMORE Birthpiaca (State or Foreign County) AUYLAND 10d. Inside City Limits 1 Yes 2 No at Country? A. American Indian, White, etc. White Dess/Industry				
Funeral Director Social Security Number Case	Birthplaca (State or Foreign Country) ATYLAND 10d. Inside City Limits 1 Yes 2 No at Country? A. American Indian, White, etc. White				
Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10c. City, Town or Location Baltimore 10d. Zip Code 10d. Zip Code 10d. Zip Code 11d. Merital Status 11d. Merita	aryland 10d. Inside City Limits 1 □ Yes 2 No at Country? A. American Indian, White, etc. White Dess/Industry				
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Type Specify	American Indian, White, etc. White Dess/Industry ME				
Armed Forces 1 Yes, Specify: 1 Yes,	White White ness/Industry				
15. Decedant's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 16. Decedent's Usual Occupation (Give kind of Work done during most of working 18. Mother's Name (First, Middle, Maiden Surmane) 18. Mother's Name (First, Middle, Maiden Surmane) 19. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Sta 20. Place of Disposition (Name of December place) 20. Decedent's Usual Occupation 19. Mother's Name (First, Middle, Maiden Surmane) 19. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Sta 20. Place of Disposition (Name of December place) 20. Decedent's Usual Occupation 19. Mother's Name (First, Middle, Maiden Surmane) 19. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Sta 20. Place of Disposition (Name of December place) 20. Decedent's Usual Occupation 19. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Sta 20. Place of Disposition (Name of December place) 20. Decedent's Usual Occupatio	White mess/Industry me				
Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	me				
Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hor Inc. Due to (or as a consequence of):					
17. Father's Name (First, Middle, Last) Albert R. Herda 19a. Informant's Name/Relationship (Type, Print) Louis V. Kahmer, Jr. (husband) 20a. Melhod of Disposition 1 Burial 2 Cremation 3 Remoyel from Stete 4 Donation 5 Liother (Specify) Hotombment 21. Signature of Funeral Service Licensee Physician Medical Examiner Physician Medical Examiner 17. Father's Name (First, Middle, Maiden Surmame) 19a. Informant's Name/Relationship (Type, Print) Louis V. Kahmer, Jr. (husband) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State 19b. Mailing Addrass (Street and Number or Rural Route Number or Rura					
4 Donation 5 Dother (Specify Entombment Lorraine Park Mausoleum 1/27/99 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Physician [Medical Examiner] Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):	itzcho				
4 Donation 5 Dotter (Specify Entombment Lorraine Park Mausoleum 1/27/99 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Physician [Medical Examiner] Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Due to (or as a consequence of): Due to (or as a consequence of):	ULLLIK				
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Physician Medical Examiner 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line. Medical Examiner Immediate Causa (Final disease or condition rasulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	236				
Physician /Medical Examiner Immediate Causa (Final disease or condition rasulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death				
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Entar Underlying					
	4)				
Cause Unsease or many C. Due See a cause of the cause of					
Cause (Disease or Injury that initiated evants resulting in death) Last Due to for as a consequence of i): Cardio Respiratory Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.					
d. Cardio Respiratory arrest					
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	bute to the cause of death?				
Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	☐ Probably 4 🖭 🗸 Tinknow				
£ Xħ					
24a. Wes an autopsy performed?	24b. Wera autopsy findings available prior to				
mple 2 2 mml	completion of cause of death?				
= F & & O	1 ☐ Yes 2 ☐ No				
25. Was case refarred to medical avanting?					
1 Sulfapatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Rasidence 6 Other					
	Specify)				
1 the Natural 5 pending investigation 1 the Natural 2 Accident 3 suicide 4 pending investigation 4 pending investigation 5 the Natural 2 the	(Specify)				
28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of City or Town, State)					
29a. Cartifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and manner (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and					
end manner stated. 29c. License number 29d. Date signed (A	or Rural Route Number, ar as stated.				
1/- 10/0	or Rural Route Number, ar as stated. I due to the cause(s)				
20 Name and address at many of the following of death (from 1921) (Tab. Dairs)	or Rural Route Number, ar as stated. d due to the cause(s) Month, Day, Year)				
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Francis Rotolo 1205 York Rd. Lutheruille, Md.	or Rural Route Number, ar as stated. d due to the cause(s) Month, Day, Year)				
State 31. Date filed (Month, Day 1) 9 C 100032. Registrate Signature	or Rural Route Number, ar as stated. d due to the cause(s) Month, Day, Year)				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death Month 7:05 P.M MARI KLOENER V. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secour Hospital Baltimore N/A 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) Days 1 M 2 F Months Hours Yrs. 218 01 1381 90 Nov. 1, 1908 Maryland Usual Rasidance of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland N/A Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 98 Smithwood Road 21228 U.S. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 14. Raca - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Biack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3℃ Widowed 4 Divorced White 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) Homemaker 8th Own Home 18. Mother's Name (First, Middla, Maiden Surnama) 17. Father's Name (First, Middle, Last) George Zivec Antonia Pshaker 19a. Informant's Name/Ralationship (Typa, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Norman Kroener / son 1423 Four Point Ct. Eldersburg, Md. 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1X Buriai 2 ☐ Cremation 3 ☐ Ramoval from State Glen Haven Memorial Park 1/22/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licengee Gonce Funeral Home P.A. what aves 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onsat and Death Immediate Cause (Final disaasa or condition resulting in death) COLON CANCER METASTATIC 2415 Due to (or as a consequence of): SIP SIGMOID COLECTOMY 1997 COLON CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disease or injury Dua to (or as a consequenca of): Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contributs to the cause of death? 1 Yss 2 No 3 Probably 4 1 Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a, State

Funeral

Director

"natural", or items 23a or 28a-f show

Director

Funeral

by

Completed

the Maryland

death

72 hours efter

be filed within 72 houtal Hygiene.

d other than "natural avent, the Wedical B

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event page.

Examiner physician end s the burial-trans Physician/Medicai 65 65 for use as ed by the a þ Completed 185 director, page Be P this After this Certification: after death.

Director: After din by the fun

The law requires that the death certificete be executed

Box 68760

Records, P.O.

Division of Vital

Physician:

Hospital or Attending

To the Hospital of within 24 hours at To the Funeral D completely filled in

that initiated evants resulting in death) Lest

ACUTE LEWKEMIA WITH ANEMIA, THROMBOUTD PENGA VAGINAL GREEDING SECONDARY TO METASTATIC COLON CANCER

24a. Was an autopsy

24b. Wera autopsy findings available prior to completion of causa of death?

1 Yes 2 TTO

1 Yes 2 No

26. Place of Death (Check only one)

25. Was case referred to medical examiner? Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1□ Yes 2☑No 28d. Describe how injury occurred 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcida 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier I met v. mogreles no 29c. License number

29d. Date signed (Month, Day, Year) 1-18-99

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANET V. W. DE HBELLI, M.D. HON ECOURS HOYPITAL. 2000 W. BALTIMORE STREET

BALTIMORE, M.D. 21023

State Registrar

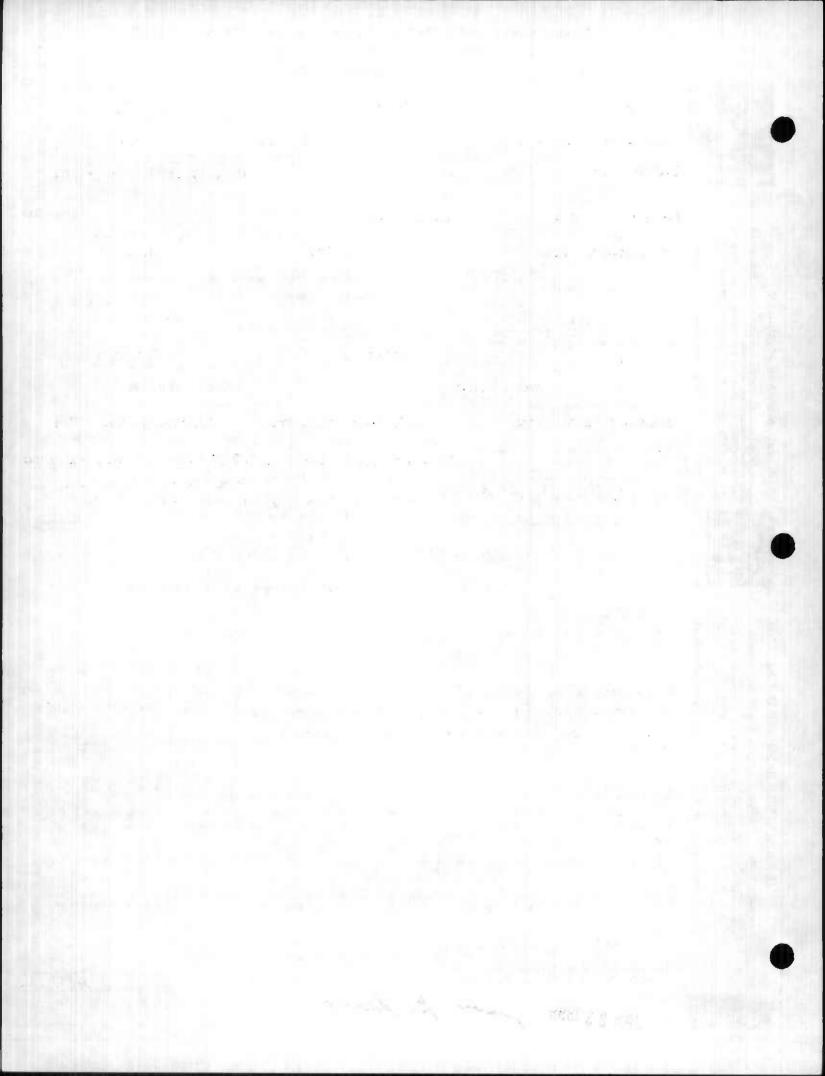
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31. Date filed (Month, Day, Year,

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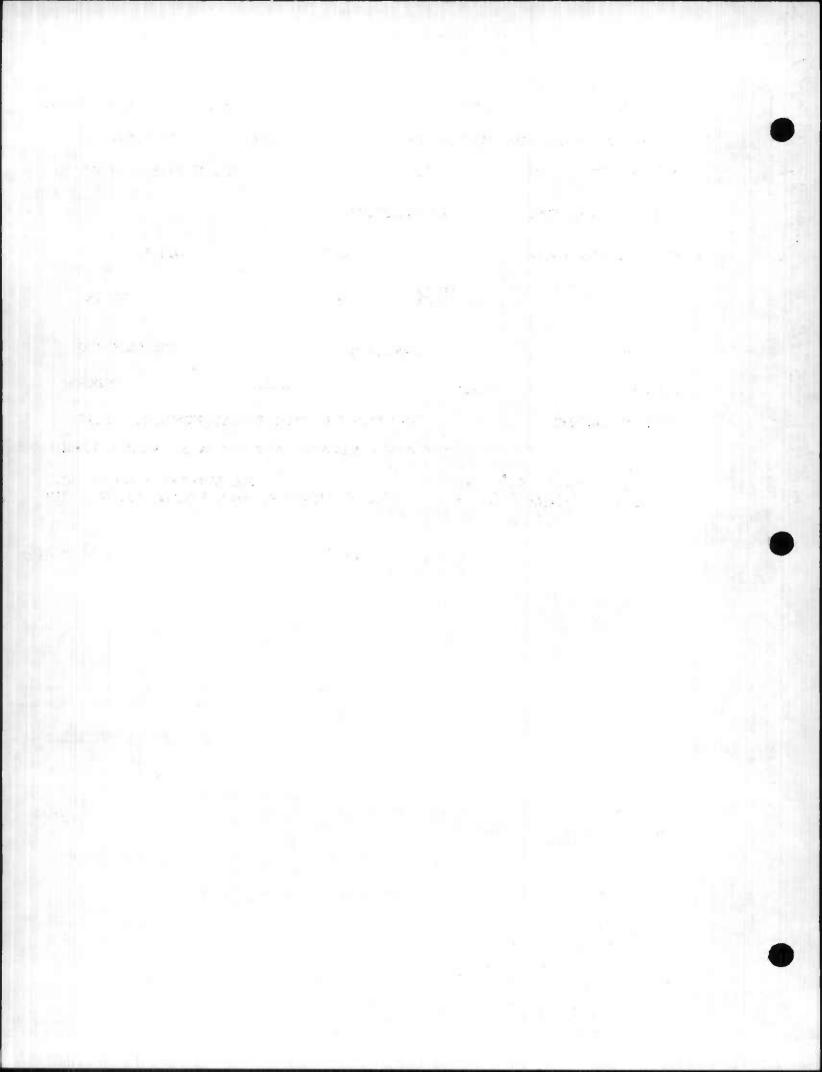




Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedant's Nama (First, Middle, Last) Month **Physician** 22 JAN. 1999 2:30PM LESTER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not Institution, give street and number) Examiner BALTIMORE HOSPICE OF BALTO. GILCHRIST CENTER TOWSON If Undar 1 Yaer | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) DEC 27, 1915 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** 1 M 2 □ F Days Min. Months Hours 83 Yrs. MARYLAND Director 215-03-5639 Usuel Rasidence of Decedant 10c. City, Town or Location 10a. State 10d. fnside City Limits 10b. County BALTIMORE RANDALLSTOWN MD 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 U.S.A. 9817 PLOWLINE DRIVE Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, 12. Was Decedent Evar in U,S. Armed Forces? r than "natural", or iten the Medical Examiner Black, Whita, atc. Armed Forces.

1 7 Yas 2 No WW TT
If Yes, Give ARMY 1 Never Married 2√2 Married 1□ Yas 2□ No Specify: Specify: WHITE þ 3 □ Widowad 4 □ Divorced Completed 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DRY CLEANING 8 PROPRIETOR 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surname) Be DELLA **GOLDBERG** KLEIN CALMAN 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Department of New Important: if them 27 is important: if them 27 is 9817 PLOWLINE DRIVE RANDALLSTOWN, MD. RUTH KLEIN/WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Data 20c. Location - City or Town, Stata OHEB SHALOM MEMORIAL PARK JAN. 24/99 REISTERSTOWN, MD 1X Burlat 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Addrass of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21208 in the disaasa, or complications/that caused the death. Do not anter tha mode of dying, such es cardiac or respiratory arrest, hear failure. List only one value on each line. Approximata Intarval Batween Onset end Deeth **Physician** /Medical Immediata Causa (Final 2 months Cancer disaasa or condition rasulting in daath) na Examiner Examiner and I-transit that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or injury that initiated evants rasulting in daath) Last Dua to (or es a consequança of): physician a s the burial-P.O. Box 68760 Physician/Medical Due to (or es e consequenca of): for use as signed by the a 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, à 24b. Wera autopsy findings available prior to complation of causa of death? 24a. Was an autopsy Completed s certificate has b 1 Yas 2 No 1 ☐ Yas 2 ☐ No Attending Physician: Be 25. Was case rafarred to medical axaminar? 26. Placa of Deeth (Check only one) director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 1 ☐ Yas 2 No Certification: To this 28c. Injury at Work? funeral 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant Director: / 6 Could not be determined 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 hin 24 hours at the Funeral Di mpletely filled is 1 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. edicai 29a. Certifier (Check only one) To the 2 You the 3 Comple 29d. Dete signed (Month, Day, Year) 29c. Licanse number 29b. Signeture and title of certified 1000 My 22, 1999 no 30. Neme and addrass of person who completed course of deeth (Item 23a) (Type, Print) N. Chales St. Belto md 21204 10 6701 31. Data filed (Month, Day, Year) 32. Registrar Signatura State JAN 26 1999 oaks Registrar **DHMH 16 Rev 6/95** ELLD O



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** ELLA VIRGINIA KEENE 4b. City, Town, or Location of Death 4c. County of Death 1999 2120 P.M. /Medical 4a Facility Name (If not institution, give street end number) **Examiner** Hospital Ce FRANKlin SQUARE Center BAITIMORE Kosed If Under 24 Hrs. 410 If Under 1 Year Birthplece (State or Foreign Country) **Funeral** Months Days 1□M 2√F Hours 219-03-0229 78 Director Jan. 2,1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Director 1 ☐ Yes 2 ☑ No Baltimore County-Fullerton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 142 Lyndale Avenue 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, While, etc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes XX No Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced Mhite 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other tha eny injury or other traumatic event, that price. 7 vrs Housekeeping-Own Home N/AHousewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Bowers Myrtyl Viola Alvater 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. William C. Keene 142 Lyndale Avenue Baltimore, Md. 21236 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stele Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Parkwood Cemetery 1-25-99 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore, Md. 21236 Bess 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immediale Cause (Finel Accident Posterior Fosse disease or condition resulting in death) Examiner Examiner VASCULITIS ARTERY Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Physician/Medicai Due to (or as a consequence of): usa i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 ☐ Unknown ARTERITIS 1em porAl 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy Completed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dale of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funerel Direcompletaly filled in by 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number

Box 68760, P.0. Records, of Vital Division or Attending

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21215-0020

altimore, Maryland

Registrar

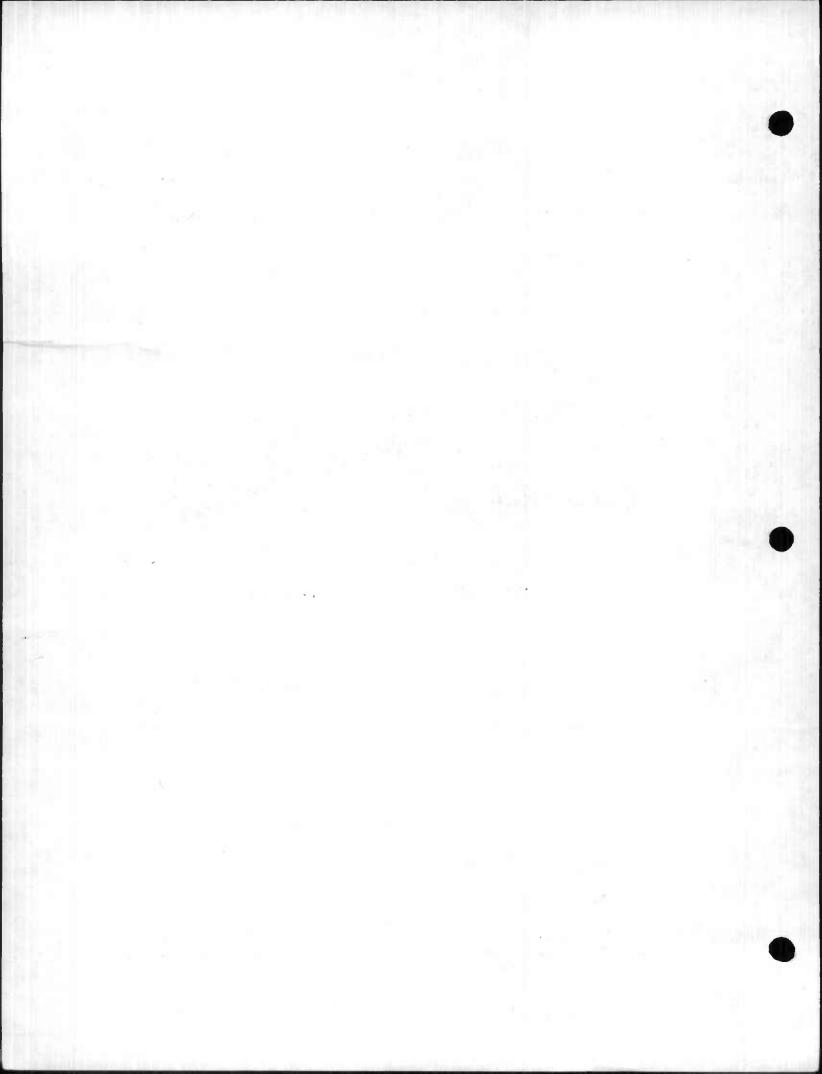
DHMH 16 Rsv 6/95

WhiTeFord SARAh 32. Registrate Signature 31. Dete filed (Month, Day, Year) JAN 26 1999 >

30. Name end address of person who completed cause of death (flem 23a) (Type, Print)

9000 FRANKlin SEUARE DR. BALTIMORG, MARYLAND

ORIGINAL



1999

3. Time of Deeth

10:06AM

Birthplece (State or Foreign Country)

GUBINSKY

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

21202

physician and the bunal-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 attending p for use as Ses signed by the a should b has certificate or Attending Physician: this After the death. Director: /

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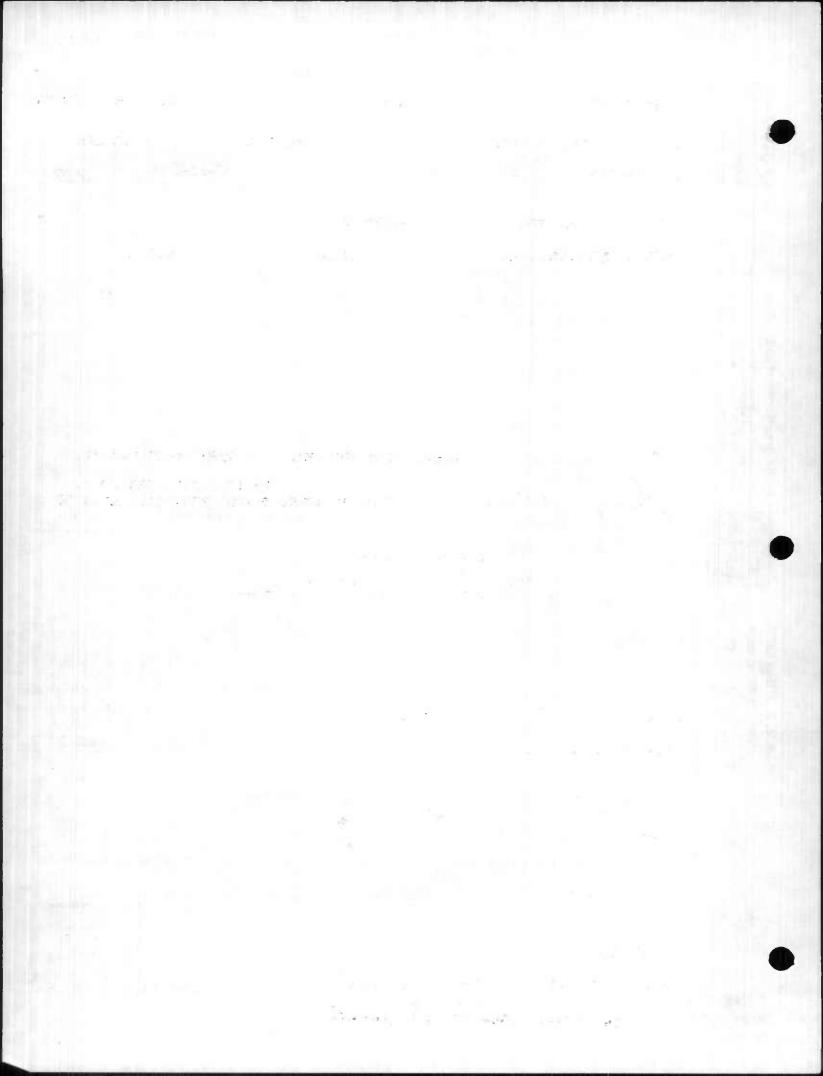
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telljuda 8900 REISTERSTOWN ROAD PIKESVILLE MD Approximete Interval Between Onset and Deeth Mes monia SOIRC 400 Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to Mis causs of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 robably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings eveilable prior to 24a. Wes en autopsy completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 1 Heaturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rure! Route Number, City or Town, Stete) 4 Homicide 1 🖰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified 30, Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print) , Kesulle, N 76 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) MPATY Pag **Physician** KLINE GERALDINE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (if not institution, give street end number) Examiner BALTIMORE BALTIMORE NORTHWEST HOSPITAL CENTER 7. Age (In yrs. lest birthday) If Under 1 Ye Months De 8. Dete of Birth (Month, Day, Year) 12–12–1918 if Under 24 Hrs. 5. Sociel Security Number **Funeral** 1 M 2 F Hours 80 212-30-4994 **Director** Usuei Residence of Decedent with the Maryland 10c. City, Town or Location 10e. Stete 10b. County r 28a-f ahow ahow Director BALTIMORE BALTIMORE 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? "natural", or items 23a or edical Examiner must be r U.S.A. 21208 permit. Pages 1 and 2 should be filed within 72 hours after death vacapartment of Health and Mental Hygiene.
Important: If Item 271s marked other than "natural", or itama 23a and highry or other traumatic event, the Medical Example mental page. 7920 SCOTTS LEVEL ROAD Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give‡ Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 Never Married 2 Merried Specify:WHITE 1 | Yes No Specify: 3 Widowed 4 □ Divorced þ Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) HOMEMAKER OWN HOME 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be (UNKNOWN) GIBSON (UNKNOWN) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Name/Reletionship (Type, Print) 5 LIGHT STREET, SUITE 510 - BALTIMORE, MD ARTHUR DRAGER / ATTORNEY 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriei 2 Cremetion 3 Removel from Stete 1/22/99 BALTIMORE HEBREW YOUNG MEN CEM. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 21. Signeture of Funerei Service Lightson **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Examiner Examiner

Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 1.9 State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Deeth 1 Decedent's Name (First Middle Last) 3. Time of Death Day 24, Month 99 January Nannie Lee 5:30am 4b. City. Town, or Location of Deeth 4a Facility Name (If not Institution, give street and number) 4c. County of Deeth Baltimore 1429 North Broadway If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Days 1 M 2 KF 217-20-9735 Yrs. 82 VA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1∏Yes 2□No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1429 N. Broadway 21213 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Black **X** Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife in home 7th Grade NA 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Ned Harris Eliza Unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) Ernest Lee 1429 N. Broadway baltimore, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Cemetery 02-01-99 Baltimore, MD 21. Signature of Fugeral Service License 22. Name and Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue eun cations that cabs Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 14 Due to (or as a consequence of). la Igarel-Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 10765 Due to (or as a consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28h Time of 28c. injury et Work? 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The lew requires that the deeth certificeta be executed P.O. Box 68760. Division of Vital Records, or Attending Physician: within 24 hours after deeth To the Funeral Director: , completaly filled in by the

Physician

/Medical

Examiner

Director

Funeral

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29a. Certifier

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25. Was case referred to medical 1 Yes 2 No 27 Manner of Death 1 Natural 2 Accident

Learnifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

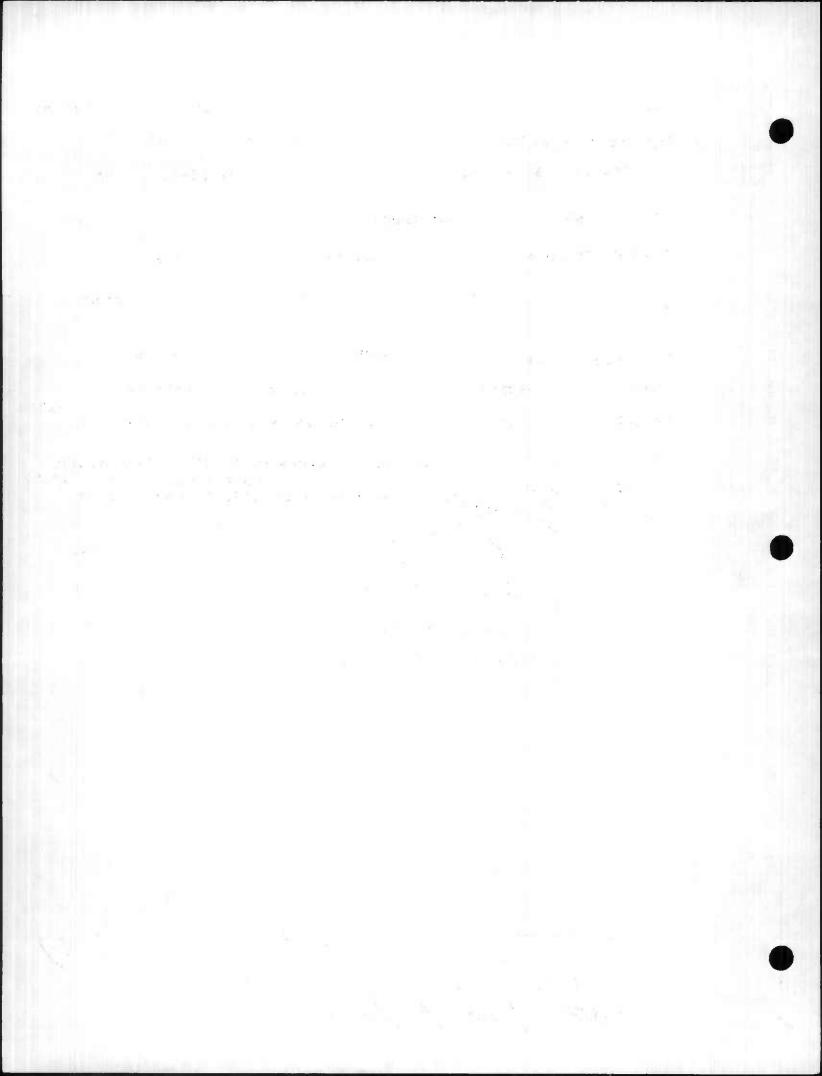
29c. License number Dool 422/ 29b. Signeture and title of certifier-

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed chase of death (Item 23a) (Type, Print) aus 21

State Registrar

31. Date filed (Month, Dey, Year) JAN 2 6 1999 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DM Month Day **Physician** CHARLOTTE 9 9 -40 JANUARO 25 4a Facility Name (If not institution, give street and number) DUKARD /Medical 4b. City, Town, or Location of Deeth 4c. County of Deat Examiner Northwest Hospital Center Randallstown Baltimore Hours Min. 8. Date of Birth Oct. 18, 1907 7. Age (In yrs. last birthday) If Under 1 Yeer 9. Birthplace (State or Foreign Maryland 5. Social Security Number 213-52-5204 **Funeral** Days 10 M 2 F 91 Months Yrs. Director Usual Residence of Decedent the Marylenc 10a State 10b Counts 10c. City. Town or Location 10d. Inside City Limits "naturel", or frems 23a or 28a-f show Owings Mills Md. Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8 Byway Rd. 21117 U.S.A. deeth Funer 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White p 3 DWidowed 4 □ Divorced Completed Pages 1 and 2 should be filed within 72 ho tent of Heelth and Mental Hygiene. nt: If Item 27 is marked other than "natur iry or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Housewife 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Annie Wolfington George Smith 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) William Francis Lockard, Jr. Son 14120 Hanover Pike, Reisterstown, Md. 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Evergreen Mem. Gardens Jan. 28, 1999 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiretory arrest, shock, or hearf failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel INFARCTION. MYUCARDIBL 10 DAYS disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner that the death certificate be executed physician end s the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that included audit and the conditions of the co Due to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 88 attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No ò The law requires 24b. Were autopsy findings available prior to Completed 24a. Wes en eutopsy performed? completion of ceuse of death? i certificate has l 1 ☐ Yes 2 No 1 Yes 2 No Physician: director, 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 □-No 1 Sinpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homleide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier milla mo 041410

Division of Vital Records, P.O. Box 68760,

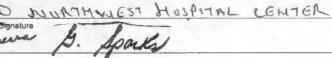
Baltimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

JOGIMBER PMEHTA MO 31. Date filed (Month, Day, Year) 32. Registi JAN 26 1999

30. Neme and eddress of person who completed ceuse of death (Item 23e) (Type, Print)



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey William J. Lewis 14:27 1999 January 21 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street end number) 4c. County of Deeth MD Mercy Medical Center Baltimore Baltimore City If Under 24 Hrs. B. Dete of Birth Hours Min. (Month, Dey, If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthpiece (State or Foreign Months 12 M 2 F Deys 218-14-003. larviana Usuel Residence of Decedent 10d. inside City Limits 10a Stete 10b. County 10c. City. Town or Location 1 XYes 2 □ No Maryland more 10f. Zip Code 10g. Citizen of Whet Country? 2442 21223 ndson 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece -American Indien, 12. Was Decedent Ever in U.S. 11. Merital Status Armed Forces?

1 X Yes 2 No
It Yes, Give Bleck White etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use (stired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 1. S. Government stodiar 18_Mother's Neme (First, Middle, Meiden Symeme) 17. Fether's Neme (First, Middle, Last) ewis bec Ve ca one 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete. Zip Code) 19e. Intorment's Neme/Relationship (Type, Print) (wite) 2442 mond 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 Burial 2 □ Cremation 3 □ Removel from State 28 rison 4 ☐ Donetion 5 ☐ Other (Specify) Tores 22. Name and Address of Facility
Toseph L. Ru 21. Signature of Funerel Service License Enter the dulease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart tuture. List only one cause on each line. Balto. Md. 21216 Approximete Intervel Between Onset end Deeth Immediate Ceuse (Finel myocardial 3 hours disease or condition resulting in deeth) ischemia disease artery Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequença of) Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably vascular disease 24b. Were eutopsy tindings eveilable prior to 24e. Wes en eutopsy performed? hypertension completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Anpatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Yes 28e. Piece of Injury - At home, term, street, tectory, offica building, etc. (Specify) 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

burial-transit end physician the Division of Vital Records, P.O. 2 has funeral director, this after death. Director: Aft

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, tra Medical Exantimer must be notified at

pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental thygiene. Important: if Nem 27 is marked other than "y any fijury or other traumetic event, trailed poice.

Physician /Medical

Examiner

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Certification: To

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Baltimore, Maryland 21215-0020

To the Hospital owithin 24 hours a To the Funeral D

ò

Tiffary Bee 31. Dete filed (Month, Dey, Year)

29e. Certifier

(Check only one)

29b. Signeture end title of certifier

29c. License number

Baltimore, mo 21201

TECertifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner as stated.

2 Madical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year) January 21, 1999

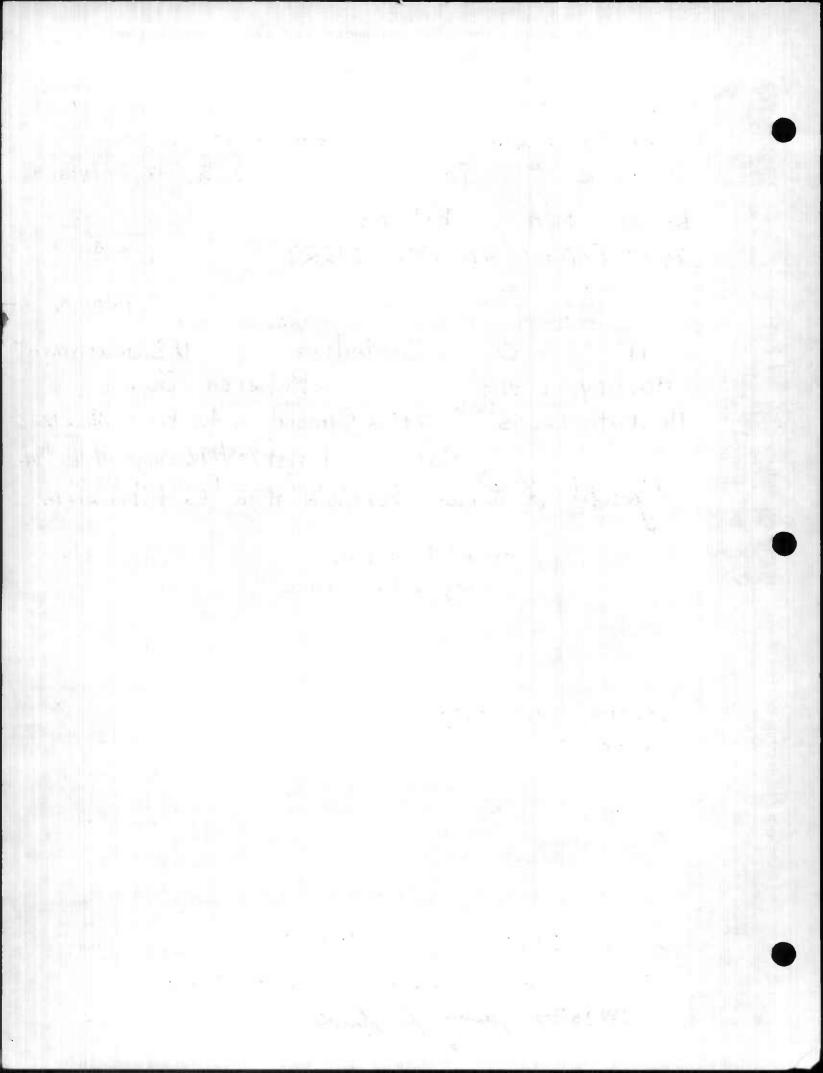
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

JAN 2 6 1999

22 S. Greene St. 32. Registrer's Signeture

DHMH 16 Rev 6/95

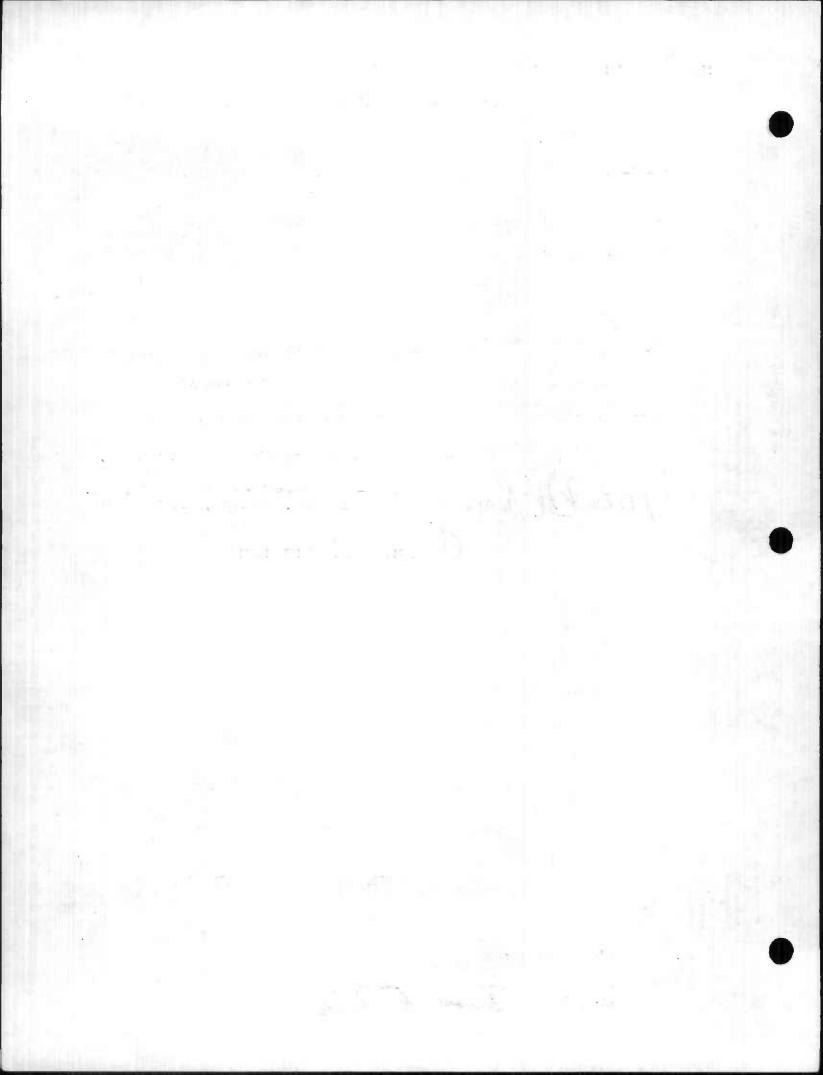
Registrar



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State of Maryland / Department of Health and Mental Hygiene Q Q 0 1 7 5 9

	1S: #23 PART I, 27, 28A 1. Decedent's Name (First, Middla, Las				Death	2. Dete of Deet	h		Tima of Death		
ysician Medical		·	lan L	ocklear		Month	Day 199	Yaar	2:25 PM		
aminer	4a Facility Nama (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death			
	8005 PULASKI H	IGHWAY			BALTIM		BAL	TIMORE			
eral ctor	5. Social Security Number 6. Security Number 218-94-4331 Usual Rasidence of Decedant	7. Aga (In yr 34	s. last birthday) Yrs.	Months Days	Hours Min.	8. Data of Birth (Month, Day, June 14	Year)	9. Birthplace Country) Maryla	(Stata or Foraign and		
H	10a. Steta 10b. County	10c. (City, Town or Loc	cation			10d. Inside City				
ral Director	Maryland Bal	timore			Dundal	.k		1	☐ Yas 2 🖾 No		
Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Country?			
all	1720 Melbourne F	Road			21222		Unite	ed State	es		
rated by Funeral	11. Meritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas:		Vas Decedent of H Yas, specify Cub ☐ Yes 253No	dispanic Origin? (S an, Mexican, Puart Specify:	pecify Yes or No- o Rican, atc.)		e - Amaricen Inc. k, Whita, atc.	dian, nite		
n, me Merical	15. Decedent's Edu (Specify only highast grad	ucetion de completed)	16a. Deced	ent's Usual Occup	pation during most of wor	kina	16b. Kind of Bu	siness/Industry			
and du	Elamentary/Secondery (0-12)	Collega (1-4or 5+)	life. D	OO NOT use retire	d)						
CO	12 Years 17. Fathar's Nama (First, Middla, Last)		Paint	ter / S	andblaste			Improv	rement		
Be	Rodney Locklear		18. Mother's Nama (First, Middle, Maiden Suman Amellee Conrad								
To	19a. Informant's Name/Relationship (T	vpe. Print)	19b. Mailine	n Address (Street	and Number or Ru			State Zin Code	9)		
5	Amelle Locklear/				e Road I						
200	20a. Method of Disposition	The second secon	Place of Dispos	sition (Nama of natory or other pla	ce)	Date 20c. Location - City or T			State		
7 9	P⊡Burlal 2 □ Cramation P□I 4 □ Donation 5 □ Other (Soucity)			Cemeter		999	Baltin	nore, Ma	aryland		
	21. Signature of Funaral Sarvice Licent	ss of Facility									
S S S S S S S S S S S S S S S S S S S	1 the by	Hamais			Funeral						
	23a. Paryl. Entar tha disease, shock, or haart failura. List only	housed the de	Do not ente	or the mode of dyi	ng, such as cerdiac	or raspiratory arr	laryland	2122: App	zoximata vat Between		
ian cal ner	Immediata Causa (Final disease or condition rasulting in death) NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of):										
Examiner	Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of):										
edicai											
clan/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to										
d by Physician/N	Part II. Other significant conditions co	23b. Did tobacco usa contribute to the cause of dear									
by Ph						1 Y	es 2∐ No	3 ☐ Probably	4 ☐ Unknow		
ete					Messale.	24a. Was e	n eutopsy ned?	available	utopsy findings e prior to ion of cause ?		
mo.						DECY	as 2 No	1 Xyas	2□ No		
director, page 2	25. Was casa rafarred to medicel axaminar?		26. Place of Dea	ath (Check only on	6)						
	1⊠ Yas 2□ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient		4 LI Nursing F	loma 5□ Rasida	nce MXOth	ar (Specify)]	AT SCENE		
2	27. Mannar of Death 1 Natural 5 Pending invastigation	28a. Data of Injury (Month, Day Year) 1-22-99	28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe 28d. Describe					oribe how injury occurred			
Certification:	2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida	28a. Place of trijury - At building, atc. (Spec	cify)			28f. Location (St City or Town BALTIMORE		er or Rural Rou 5 PULASK	te Number. HWY.,		
edical C	29a. Catifiar . 1 Certifying Phy Medical Exami	siclan: To the best of my kr iner: On the basis of axamir and mannar stated.	nowledge, death	occurred at the ti	me, date and place opinion, death occu	and dua to the ca	eusa(s) and ma	nnar as stated. and due to tha	cause(s)		
complately filled in by	29b. 5 charten end titla of certifiar	and the state of t		29c. Licens	se number	2	9d. Data signe	d (Month, Day,	Year)		
0	11/11/20	le mo		0	.C.M.E		JAN.	23, 199			
	3 Name and address of person who co	ompiated ceusa of death (Ite	em 23a) (Type P	Print)							
	Number and address of person who co	ompiated ceusa of death (Ite			, Baltimo	ore, Marv	land 21	201			



DHMH 16 Bay 6/95

Registrar

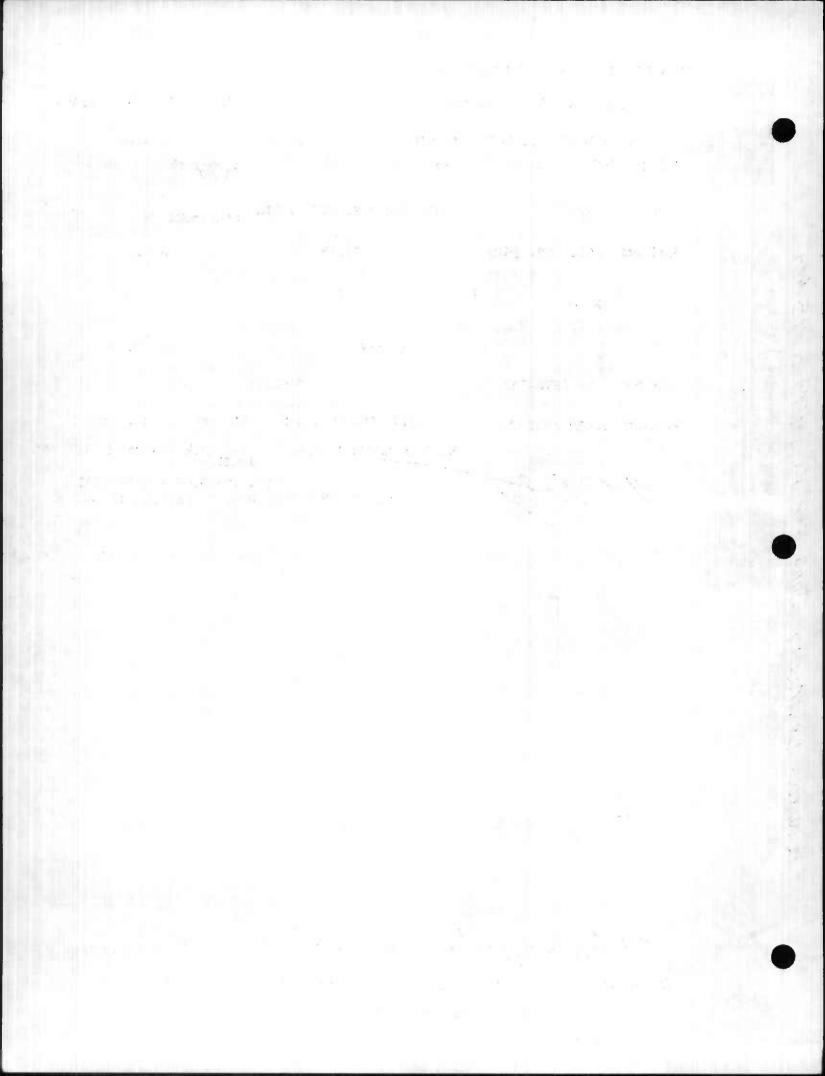
JAN 26 1999

Aspers they in a many water but it

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Items: 7,10c,20b per F.H-G-767 1/26/99 reb Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** JAN 19ay 1999 **EDWARD** 6:45AM RALPH LEVENSON /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner HOSPICE OF BALTO. GILCHRIST CENTER TOWSON BALTIMORE 7. Age (In yrs, lest birthdey) 6. Sex 1X M 2□ F Birthplace (State or Foreign
 Mauntry) **Funeral** Months Deys Hours Yrs. **Director** Usual Residence of Decedent the Manyland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Madical Examiner must be not that all MD 6317 PARK HTS. AVE. # 510 N/A 1 X Yes 2 No BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 6317 PARK HTS. AVE. #510 21215 Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married Specif WHITE 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) se filed within 7 el Hygiene. Elementery/Secondary (0-12) College (14 or 5+) **BROKER INSURANCE** 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) h and Mentel H SYDNEY LEVENSON PAULINE GOLD 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) of Health 6317 PARK HTS. AVE. # 510 BALTO. MD. PAULINE GILDEN /MOTHER 20b. Plece of Disposition (Name of BETH CL COMPANY) 20a. Method of Disposition

↑□ Buriel 2 □ Cremetion 3 □ Removel from State 20c. Location - City or Town, Stete permit. Pegas Department of Important: If it any injury or o JAN21 RANDALLSTOWN MD Jan.21,99 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fedility SOL LEVINSON & BROS. INC. 21208 8900 REISTERSTOWN ROAD PIKESVILLE MD not allows thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) concer of the paratidglan Examiner Due to (or as a consequence of): Examine physician and s the burial-transit certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Physician/Medical 1 evenson Due to (or as a consequence of) 88 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. tha 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed by þ 24b. Were eutopsy findings available prior to completion of cause Completed 24a. Was an autopsy peen certificeta has 28 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hosp, Ce 1 Yes 2 No To this funeral 27 Menner of Death 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b Time of Certification: Aftar 5 Pending 1 Neturel 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 D Homicide ò 24 hours a Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) and menner stated. 29a. Certifier Medical pletaly (Check only one) To the To the I 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 25205 They, mo 30. Name and address of person who completed cause of deeth Them 23a) (Type, Print) Charles St. Balto, and 2,204 EBMC U 6701 32. Registrar's Signeture JAN 26 1999 sporks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Q Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JAN 20°1999 Year **JEAN** LAVIGNE 10:30AM 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5 Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth Month, Day Year DEC 20 1911 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min MARYLAND 87/rs. 217-01-9951 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limital 10a. Stete BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4204 OLD MILFORD MILL ROAD 21208 U. S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married SpecifWHITE 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 Divorced Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) HARRY WARANCH HELEN KARKLIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALAN BLUM / NEPHEW 2106 SUGARCONE ROAD BALTIMORE MD. 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ADATH YESHURUN (SODOVA) 12 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/24/99 BALTIMORE MD. CEMETERY 21. Signature # Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE MD. 21208 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, dist only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Mu monic Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in death) Last Due to (or as a consequence of) Juv (1 Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown ai Hak 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy 1 Tyes 2 No 1 Yes 21 No 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending 1 Yes 2 No Investigation

The law requires that the deeth certificate be executed attending physician and for use es the buriel-tran Division of Vital Records, P.O. Box 68760 80 the s been signed by the should be deteched hes le 2 page certificate : After this certificar e funeral director, p Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifical etely filled in by the funeral director. To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23a

Director

Funeral

g

Completed

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinations to be notified as

permit. Pages 1 and 2 should be filed within 72 hours efter d
Department of Health end Mental Hygiene.
Important: if item 27 is marked other than "naturel; or item
any lajury or other traumatic event, its Medical Exercises.

Physician /Medical

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Certification: To

Medical

Baitimore, Maryland 21215-0020

the Marylend

death with

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and menner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

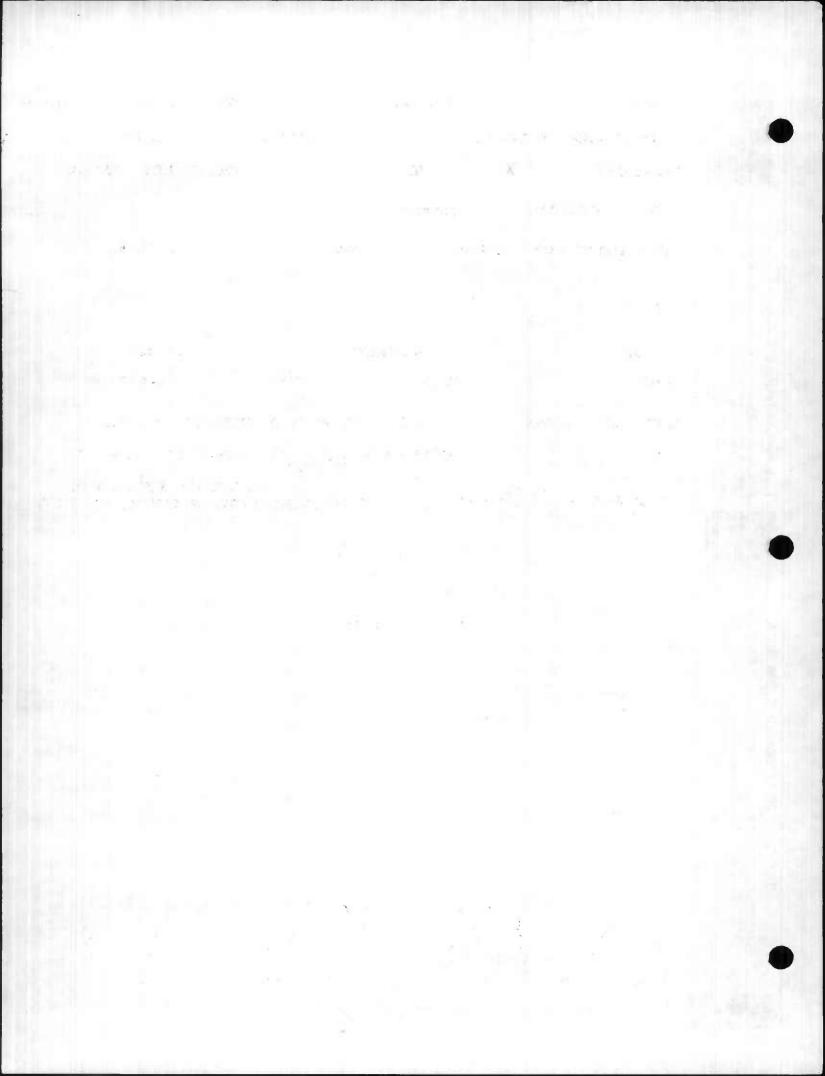
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30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) WISTER, no lilha 4000 old Courd Ad;

State Registrar JAN 26 1999

TED-

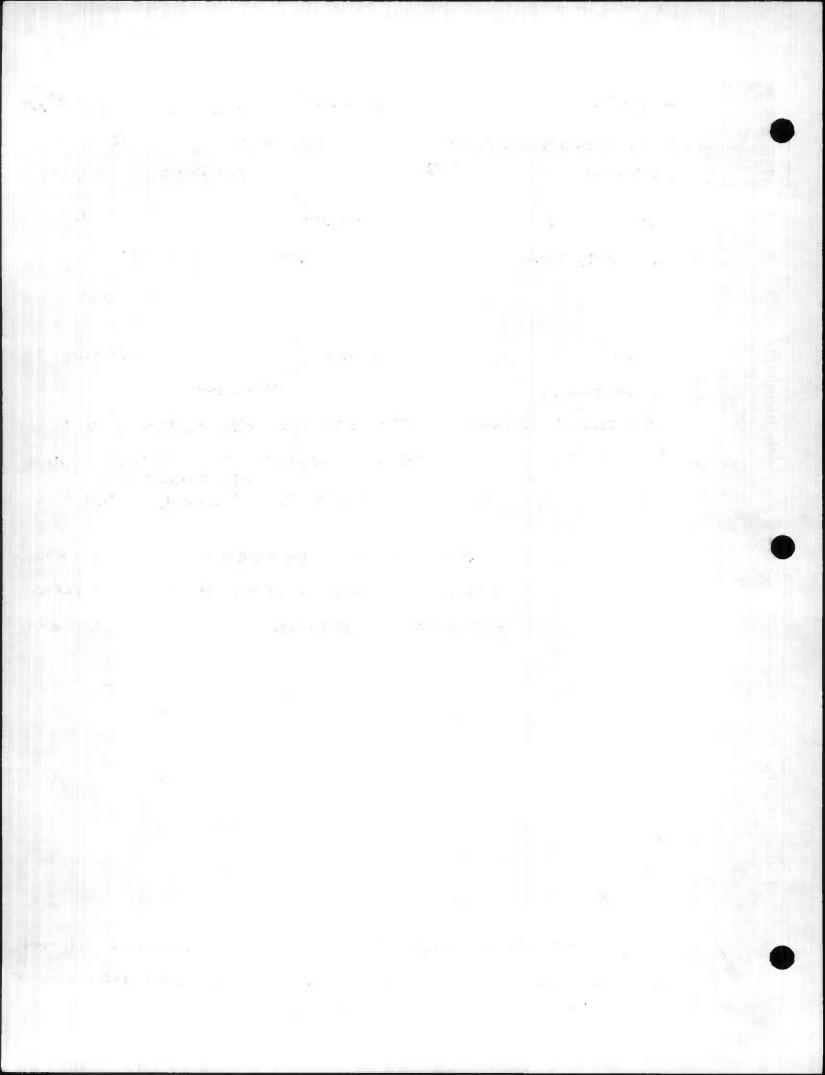
32. Registrat's Signature 31. Dete filed (Month, Day, Year)



		Certifica	te of Death		Reg. No.		
1. Decedent's Name (First, Middle, Last)			2. Dete of De	eth Day	Year 3. Tim	e of Death
cian ROBERT		MC	INTOSH	JANUAR	121,1	999 19	I PM
iner 4a Facility Name (If not Institution, give	4		-	r Location of Deet			
JOHNS HOPKINS	HOSPITAL		BALTIN			N/A	
5. Social Security Number 6. Se 214-76-7233		37 Yrs. Month:	er 1 Year If Under 24 H s Days Hours Mi		, 1961	9. Birthplace (Sta Country) Mary	te or Foreign
Usual Residence of Decedent	1.0-0					1	
10a. State 10b. County		ity, Town or Location					City Limits
g Md N/	A		ltimore				'es 2□No
Md N/		10f. 2	ip Code		10g. Citizen of V	What Country?	
2760 Tivoly Aver	nue		21218			SA	
2760 Tivoly Aver	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pue	(Specify Yes or No erto Rican, atc.)	- 14. Raci	e - American Indier ck, White, etc.	
3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Datas:	1 ☐ Yes	2™ No Specify:		Specify	Black	
15. Decedent's Edu		16e. Decedent's Us	ual Occupation		16b. Kind of Bu	usiness/industry	
15. Decedent's Edu (Specify only highest great Elemantery/Secondary (0-12)	le completed) College (1-4or 5+)	Give kind of v	vork dona during most of w use retired)	urking			
12th		Engi	ineer		Hou	sekeeping	3
17. Father's Neme (First, Middle, Last)		-		ama (First, Middle,			
Willis McIntosh			Eth	el Jones			
19a. Informant's Name/Relationship (7)	rpe, Print)	19b. Mailing Addre	ss (Street end Number or		er, City or Town,	Stata, Zip Code)	
Ethel McIntosh	(Mother)	2760 Ti	voly Avenue	Raltimore	Marw1	and 2121	Q
20a. Method of Disposition	20b.	Place of Disposition (N	eme of	Date	20c. Location -	City or Town, State	
Burial 2 Cremation 3 F	temovel from State	cemetery, cremetory or	em Gardens 1	127/00	n-1-:		1 1
4 Donation 5 Other (Specify)						ore, Mar	yland
21. Signature of Funeral Service Licans	ee 1	22. Name	and Address of Fecility	Caple Fur	neral Se	rvice	
Rand	(5)	5502	Winner Aven	ue Baltin	nore, Ma	ryland 2	1215
Part Enter the disease, or comp nock, or haart failure. List only o	ications thet caused the dea	th. Do not enter the me	ode of dylng, such es card	ac or respiretory e	rrest,	Approxi Interval	mete Batween
						Onsat a	nd Death
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c a		or es a consaquence of		') '''	1		AQC
Sequentially list conditions						7 10	ARS
Sequentially list conditions, if any, leading to immediata cuese. Enter Underlying							
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Cause (Disease or Injury that initiated events resulting in death) Last	RETROV		ISEASE				
Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or es e consequenca of	OISEASE):				
Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or es e consequenca of	OISEASE):	23b. Dld	tobacco use con		EARS
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions con	Due to (or es e consequenca of	OISEASE):		tobacco use coi Yes 2× No	∠ V E	EARS
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions conditions	Due to (or es e consequenca of	OISEASE):	10	Yes 2No	ntribute to the cau	Se of death
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions conditions	Due to (or es e consequenca of	OISEASE):	1 🗆	V	ntribute to the cau 3 Probably 24b. Were eutor available pr	se of death
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions con	Due to (or es e consequenca of	OISEASE):	1 🗆	Yes 2 No	2_ VE	se of death
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions con	Due to (or es e consequenca of	OISEASE):	1 🗆	Yes 2 No an eutopsy ormed?	ntribute to the cau 3 Probebly 24b. Were eutor available prompletion of death?	se of death
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions	Due to (or es e consequenca of): cause given in Pert I.	1 □ 24e. Wes perfo	an eutopsyrmed?	ntribute to the cau 3 Probebly 24b. Were eutor available prompletion of death?	se of death. Unknownsy findings for to of cause
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Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions	Due to (d	or es e consequenca of sulting in the underlying sulting sulting in the underlying sulting sul	26. Pleca of DOA Other: 4 Nursing 28c. injury et Work?	24e. Wes perfo	Yes 2 No an eutopsy rmed? Yes 2 No one) dence 6 □Oth how injury occurr	ntribute to the cau 3 Probably 24b. Were eutor available prompletion of death? 1 Yas	se of death. Unknownsy findings for to of cause
Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions	Due to (d	or es e consequenca of sulting in the underlying in th	26. Pleca of DOA Other: 4 Nursing 28c. injury et Work?	24e. Wes perfo	Yes 2 No an eutopsy rmed? Yes 2 No one) dence 6 □Oth how injury occur Street and Numb	Tribute to the cau 3 Probably 24b. Were eutor available prompletion of death? 1 Yas	se of death. Unknownsy findings for to of cause
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Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions	Due to (d	DER/Outpatient 3 Interest Injury Meaning the Injury Meaning of Injury Meaning the Injury Meaning of Injury Meaning the Injury M	26. Pleca of DOA Other: 4 Nursing 28c. Injury et Work? 1 Yes 2 No ony, office	24e. Wes performed to the control of	Yes 2 No an eutopsy med? Yes 2 No one) dence 6 □Oth how injury occurr Street and Numb wn, Stete) ceuse(s) and ma dete end pleca,	ntributa to the cau 3 Probebly 24b. Were eutor available pr completion of death? 1 Yas er (Specify) red per or Rural Route is anner es steted, end due to the cau	se of death. Unknow isy findings ior to of cause No
Part II. Other significant conditions condit	Due to (d	or es e consequenca of sulting in the underlying sulting in the underlying sulting in the underlying sulting in the underlying M. Time of Injury M. Tome, farm, street, factority)	26. Pleca of DOA Other: 26. Pleca of DOA Other: 4 Nursing 28c. Injury et Work? 1 Yes 2 No Nory, office d et tha time, date and ple on, in my opinion, death oc 9c. License number	24e. Wes performed to the control of	Yes 2 No an eutopsy rmed? Yes 2 No one) dence 6 □Oth how Injury occur Street and Numb wn, Stete) ceuse(s) and ma dete end pleca, 29d. Dete signe-	ntribute to the cau 3 Probably 24b. Were eutor available prompletion of death? 1 Yas er (Specify) red per or Rural Route if the cau anner es steted, end due to the cau d (Month, Dey, Yes	se of death. Unknow sey findings for to of cause No Vumber, se(s)
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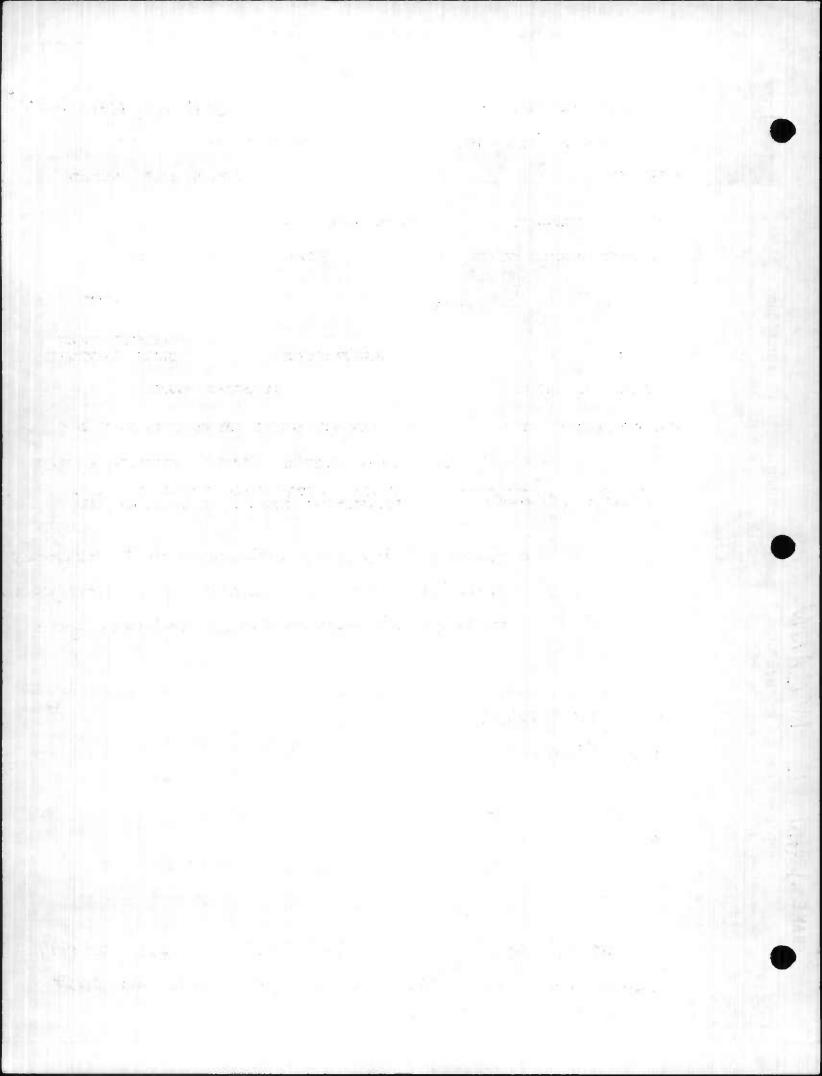
DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 02,30 JOHN LAWRENCE McCANN /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Agnes Hospita N/A If Under 1 Year | If Under 24 Hrs. | 5 Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 10 M 2□ F Months Days Hours Yrs. 81 Director 215-05-6061 JUNE 5, 1917 MARYLAND Usual Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f ehov mant be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE CATONSVILLE the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 76 NORTH PROSPECT AVENUE 21228 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1∑Yas 2□ No If Yes, Give Yeer or Detes;₩W II "natural", or items Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐XMarried 1 Yes 2₺ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced i Hygiene. other than "natura ent, fre Medical E Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mentel Hygiene. BALTIMORE COUNTY Elementery/Secondary (0-12) College (1-4or 5+) 12 POLICE OFFICER POLICE DEPARTMENT 7 ie marked other treumatic event, 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JAMES J. McCANN KATHERINE GUNDLACH 19b. Mailing Addrass (Streat end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health CATHERINE McCANN, WIFE 76 N. PROSPECT AVENUE, CATONSVILLE, MD 21228 Baltimore. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 20a. Mathod of Disposition Peges 1 1 Burial 2 □ Cramation 3 □ Ramovel from State = 0 ortant: I 4 ☐ Donation 5 ☐ Other (Specify) NEW CATHEDRAL CEMETERY 1/27 BALTIMORE, MARYLAND Depenting Importation and Injury 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. tanks 736 EDMONDSON AVENUE, BALTIMORE, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel end Deeth **Physician** with mass effect /Medical Immediate Cause (Final disease or condition rasulting in death) Examiner Examiner cances 1-10 years Sequantially list conditions, if eny, laading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in deeth) Last supraventricular tachycardy Paroxysmal Physician/Medical Due to (r as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably And Onknown à 24b. Were autopsy findings eveilable prior to Completed 24a. Was an autopsy Hypo Hyroidism completion of cause of deeth? 1 Yes 2000 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Wes case referred to medical Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No 1 Enpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Vatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accidant 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) Within 2 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifier 29c. License number anuary 30. Nama end addrass of person who completed causa of daath (Item 23a) (Type, Print) Arbuhes Md Huefner 1518 Sulphur Spr my Rd MD JAN 26 32. Registrar's Signature State Registrar FFF DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Hazel F. Montgomery 2:08 AM 25 January 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Square Baltimore HOSPITAL Rosedale -ranklin enter If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov 24, 1907 If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 M XXF 215-07-0917 91 Mary land Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 N Yes 2 No Maryland Baltimore Co. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5811 Westwood Avenue 21206 U.S.A 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Rice's Bakery Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Albert F. Wolf Emma Shawberry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Beverly Miller (Daughter) 5811 Westwood Avenue, Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date T☐Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐Donation 5 ☐Other (Specify) Lorraine Park Cemetery 1/28/99 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility A. Alan Seitz, Jr. Funeral Home llan 3818 Roland Avenue, Baltimore, Maryland 21211 23a. Part. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause or each line. Approximata Intervai Between Onset and Death ACUTE MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in deeth) WO HOURS ATHEROSCLEROTIC CORONARY VASCULAR DISEASE TEN YEARS Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No CONGESTIVE FAILURE 1 Yea 3 Probably 4 Unknown HEART 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referre to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 FR/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examine Box 68760 P.O. Records. Division of Vital

this or Attending s after death. within 24 hours a To the Funeral C completely

Physician

/Medical

Examiner

Funeral

Director

28a-f show

6

Norms 23a

"natural", or

Department of Health and Mental Hygie Important: If fram 27 is marked other any injury or other traumatic avent, tr pnce.

Physician

/Medical

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Physician/Medical

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Completed

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Certification: To

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Pages 1 and 2 should be nent of Health and Mental

Baitimore.

Directo

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DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year) JAN 2 6 1999

29b. Signature and little of certified

30. Name and address of person

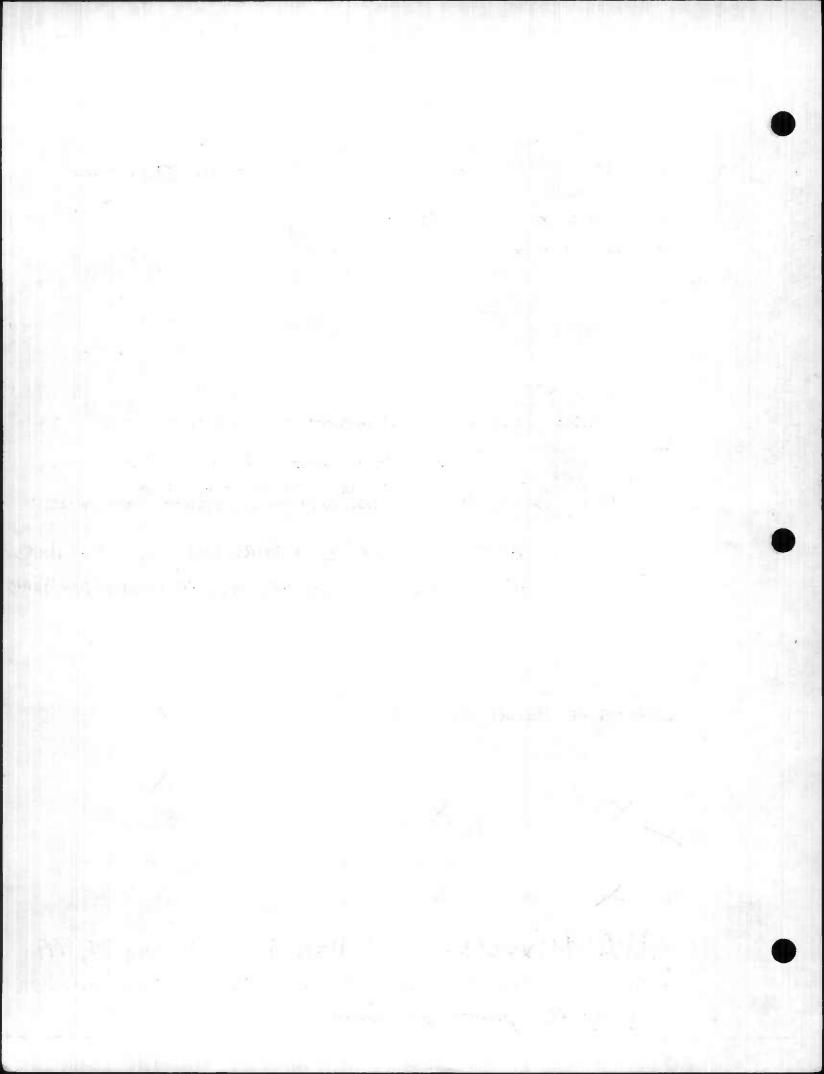
KMAN 32. Registrar's Signature

who completed ceuse of death (Item 23a) (Type, Print)

1308 Business Center Way #102 Edgewood MD 21040

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas Charles Martin, Sr. anuary /Medical 4c. County of Dee 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location Examiner cosedale Franklin quake Hospita enter Iti Move If Under 24 Hrs. If Under 1 Year Months | Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiaca (State or Foreign Country) 8. Daie of Birth (Month, Day, **Funeral** Days 1 ☑ M 2 □ F Hours Maryland Director 66 Dec. 219-28-6281 Usual Rasidence of Decedeni 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director 28a-1 Baltimore Edgemere Maryland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ð 21219 United States 'natural', or Items 23a 7713 Seekford Road 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ② No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Rece - American Indian Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: White Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Steel Industry Steelworker 8 Years 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be and Mental Esther Grammar Elzie Martin Pages 1 and 2 should 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) important: if item 27 is any injury or other tracestor. 7713 Seekford Road Edgemere, Maryland Mrs. Mary Jane Martin/Wife 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata ъ XIX Buriai 2 ☐ Cremation 3 ☐ Ramovai from State Bel Air Memorial Gdns. 1/25/99 Bel Air, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Junaral Service Licensea 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, MD 7922 Wise Ave. Enter the offense, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, or heart source. Let gray one cause on each line. Approximeta intarval Batween Onset and Deeth **Physician** · Carcino Ma /Medical Immediata Causa (Final diseese or condition rasulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760 Dua to (or es a consequança of) use P.0. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ The law requires 24b. Wara sutopsy findings available prior to completion of cause of death? page 2 should 24a. Was an autopsy performed? Completed certificate has 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) Certification: To 1 Yes 2 No this funeral 27 Manner of Death 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? After Division 1 Naturai 5 Panding invastigation 1 Yas 2 No 24 hours after death. 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 To the 29b. Signeture and life of certifier 29c. License number 29d. Data signed (Month, Day, Year) nari 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

State Registrar

yvaldo

Month, Day, Year

6 1999

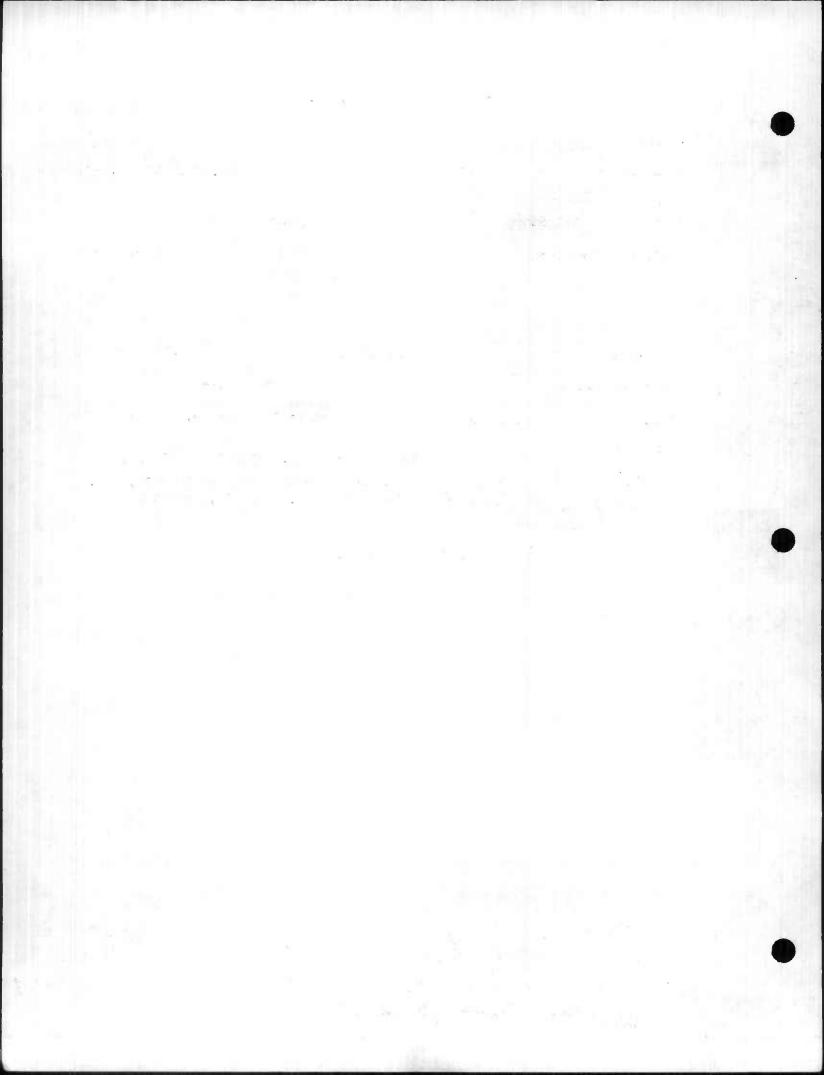
31. Data filed

DHMH 16 Rev 6/95

9000 Franklin

32. Registrar's Signatura

Square Drive Baltimore, Maryland 21237



DIVISION OF VITAL RECORDS, P.O. BOX 68760

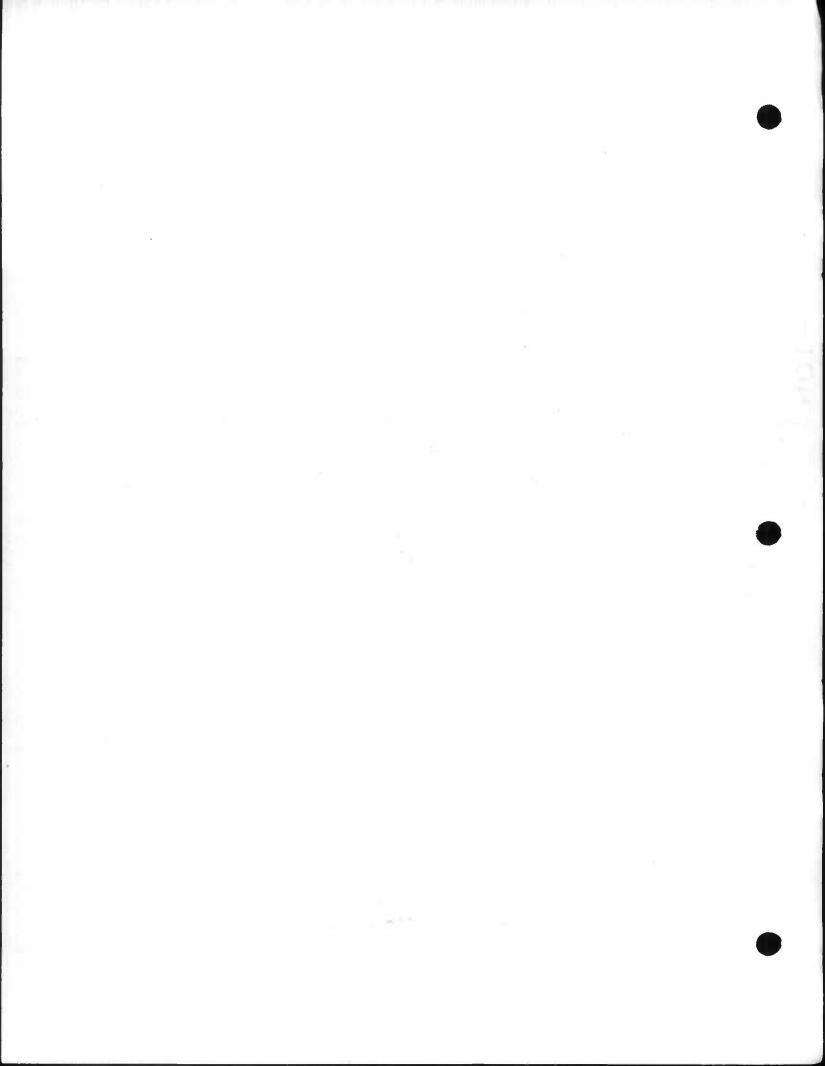
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLA	ND / DEPARTMENT	OF HEALTH AND I	MENTAL HYGIENI REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest)	2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH					
1	CLARE ELIZABETH MO	January 20		12:50 pm M				
		yrs. lest birthday) IF UNDER	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRT	NPLACE (State or Foreign		
	N/A 1 □ M 2 🔀 F	YRS.	1 05	1/20/99		laryland		
œ	90. FACILITY NAME (M not institution, give street and number) Greater Baltimore Medical Cent		r, town or location of de $\Gamma { m owson}$	ATH	Sc. COUNTY OF Balti			
5	RESIDENCE OF DECEDENT		TOWSOII		Daili	THOLE		
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOWN				10d. INSIDE CITY LIMITS?		
	Maryland N/A	Baltime				1 XYES 2 NO		
FUNERAL	100. STREET AND NUMBER 417 Rodgers Court		101. ZIP CODE 21212					
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN	U.S. ARMED 13.	WAS DECENDENT OF NISPAN			CE American Indien,		
ВУ Е	1 Never Married 2 Married FORCES? 1 YES IF YES, GIVE WAR OR DAT		If yes, specify Cuban, Mexices 1 YES 2 NO Specify		Spe	ck, White, atc.		
		18a. DECEDENT'S USUAL O	CCUBATION	Unknown		White		
ETE	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done life. Do NOT use retired.)	during most of working	166. KIND OF BUSI	INESS/INDUSTRY			
IPL	N/A N/A	N/A		N/A				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Maiden S	Surname)			
BE		Mosmiller	Elizabe		Rohla	nd		
5	19a. INFORMANT'S NAME (Type/Print)		S (Street and Number or Rural F		1.1	01010		
	G.B.M.C. PATHOLOGY 20a. METHOD OF DISPOSITION	LACEAND DATE OF DISPOS	rth Charles		ATION - City or 1			
		lery, cremetory or other place) een Mount	Crematory	01/23/99	Balto	own, Stata		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22.	NAME AND AGORESS OF FAC	CILITY				
_ 7	William Jane 14	I I	Henry W. Je 1905 York H	enkins & Rd. Balto	Sons C	21212.		
	23. PART I. Enter the diseases, or complications that caused	the deeth. Do not enter				Approximate		
	ahock, or heert fallure. List only one ceuse on esc IMMEDIATE CAUSE (Final	on line.				interval Between Onaet and Death		
	disesse or condition a.	lung						
	DUE TO (OR AS A C	CONSEQUENCE OF:						
O.	Sequentially list conditions, if any, leading to immediate	CONSEQUENCE OF):						
CAT	cause, Enter UNDERLYING CAUSE (Disease or Injury							
E	that initiated events resulting in deeth) LAST	CONSEQUENCE OF):						
CERTIFICATION	d							
AL	PART II. Other significent conditions contributing to deeth but	t not resulting in the u	nderlying ceuse given in	Part I. 24s. WAS AN A		b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
MEDIC				1 YES 2		COMPLETION OF CAUSE OF DEATH?		
ME						1 TES 27 NO		
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL	DEATH YES B. PLACE OF DEATH (Check		1 🗆 📗				
Sici	EXAMINER? 1 YES 2X NO 1 Kinpetient 2 ER/Outpet	OTHE	۹:					
PHYSICIAN:	27. MANNER OF DEATH 28a. DATE OF INJURY	28b. TIME OF	aling Home 5 - Residence	28d. DESCRIBE HOW IN	JURY OCCURED			
ВУР	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY M	WORK? 1 YES 2 NO					
		At home, farm, street, tac	tory, office	28f. LOCATION (Street ar City or Town, State)	nd Number or Rural	Route Number,		
COMPLETED								
MPL	29a. CERTIFIER (Check only one)							
00	One) 2 MEDICAL EXAMINER: On the basis of examination a	and/or investigation, to my o	ptnion, death occured at the	time, data and place, and	due to the cause	(a) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		M420		29d. DATE SIGNE	D (Month, Day, Year)		
2	39 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	'N (ITEM 27) (Type Print)	17900	//	- 1/20	777		
	Jeffrey Pomerance, M.D. 670	N. Charles	Street, Bal	Ltimore, MI	21204			
	31. DATE FILED (Month, Day, Year) 32. 9EGISTRAR'S, SIGNAL	CURE						
	JAN 2 6 1999 Seneral	B. Low	les!					





BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be created as the burial-transit permit.	
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HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phys	unera	and or item 23 shows any failure as other traumatic event the medical examiner must be notified at once
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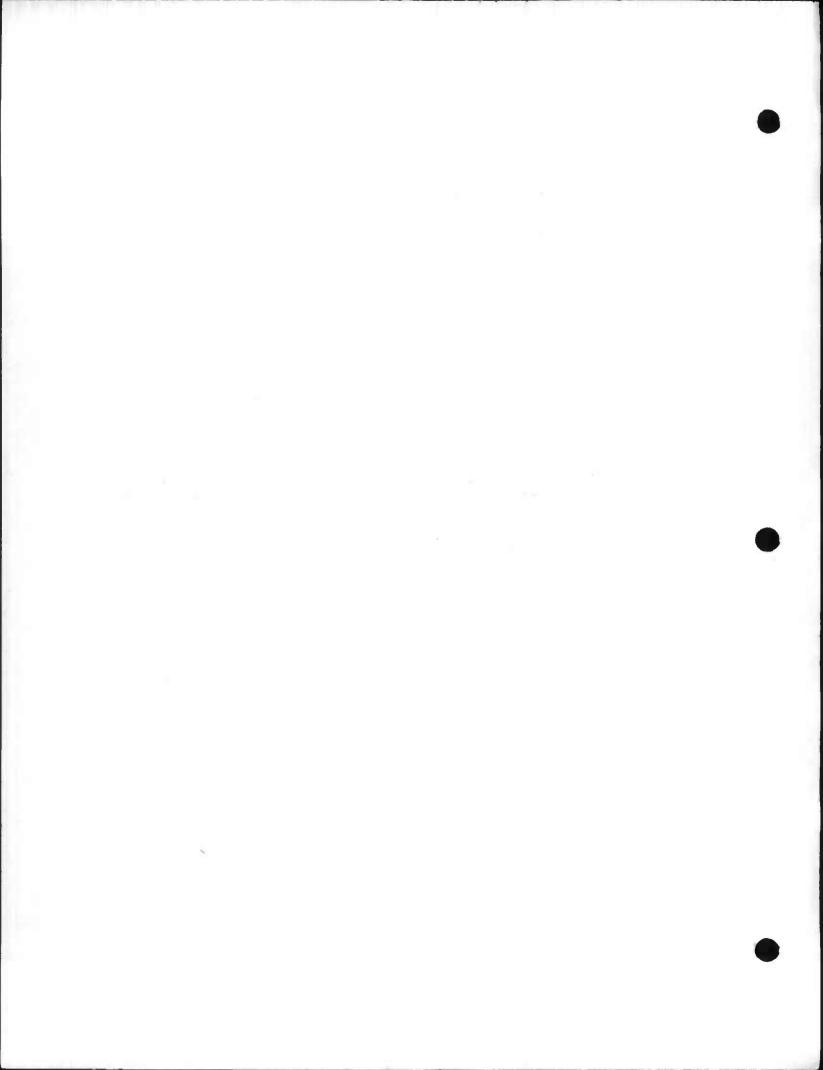
31. DATE FILED (Month, Day, Year)

JAN 2 6 1999

222

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH KELLY ANN MOSMILLER 12:16 20 January 1999 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFTH (Month, Day, Your 8. BIRTHPLACE (State or Foreign DAYS MIN. 36 N/A 1 M 2 F YRS. 1/20/99 BALTIMORE 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Greater Baltimore Medical Center Towson Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n /a BALTIMORE 1 YES 2 NO 10a STREET AND NUMBER 101 ZIP CODE 100 CITIZEN OF WHAT COUNTRY? 417 RODGERS COURT 21212 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 YES 2 NO Specify: Specify. 3 Widowed 4 Divorced UNKNOWN WHITE 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A N/A 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) JOHN MOSMILLER ELIZABETH ROHLAND 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) G.B.M.C. PATHOLOGY 6701 North Charles ST. Towson, Md. 21204. 20a. METHOD OF DISPOSITION
1 ☐ Burlai 2 X Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata Green Mount crematory 01/28/99 Balto., Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Henry W. Jenkins & Sons Co. Willian laus. 4905 York Rd. Balto., Md. 111 21212. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximate ahock, or haart failure. List only one cause on each line. Intarval Between **IMMEDIATE CAUSE (Finel Onset and Death** disesse or condition resulting in death) DUE TO (OR AS A CONSPICENCE OF) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 X NO DE DEATHS 1 TYES 2 TO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, **EXAMINER?** HOSPITAL: OTHER 1 YES 2 NO 1 Xinpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO 2 Accident Investigation 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28a, PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 3 Suicide 8 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 200 MIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

146 M42071 99 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeffrey Pomerance, M.D. 6701 N. Charles Street, Baltimore, MD 21204 32. REGISTRAR'S SIGNATURE DHMH-16 Rev 1/89



State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Daeth 3. Time of Death Day Month Yaai Physician 9:10 Am 20, 1999 GLADYS MAE GAWTHROP MILLER January /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital Sinai N/A It Undar 1 Yaer | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthpiace (Stata or Foraign Country) **Funeral** Deys Months Hours Min 1□ M 2\ F Yrs. Director 92 Aug. 8, 1906 214-40-5341 Usual Rasidence of Dacedant Maryland the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnsida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 17 Yes 2 No Directo Maryland | N/A Baltimore City 10g. Citizan of What Country? ò Herns 23a 840 W. 40th Street #214 21211 USA death Funerai 12. Wes Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Give Yaar or Datas: Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 72 hours after 1 □ Nevar Married 2 □ Married "natural", or 1 ☐ Yas 2 No Specify: by 3 X Widowed 4 □ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Dacedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) High School Teacher Education yrs other 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) should be and Mental is marked J. William Gawthorp E. Edith Wilson 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) permit. Pages 1 and 2: Department of Health ar Important: if item 27 is any injury or other traugues. Pages 1 and 2 Mrs. Judith M. McCall (Dghtr) 1306 Gateshead Road, Baltimore, Maryland 21286

20a. Mathod of Disposition

20b. Place of Disposition (Name of Comparison 3 Department of Comparison)

20c. Location - City or Town, State 1 ☐ Buriai 2 X Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Dulaney Valley Mem Grdns 1/22/99 Baltimore, Maryland 21. Signature of Funeral Service Do 22. Nama and Addrass of Facility Mitchell-Wiedefeld Home, Inc. Dalagorium 23a. Part1. Entar tha disaasa, or complications that causad tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, interval Between Onsat and Death **Physician** /Medicai immediata Causa (Final disease or condition rasulting in daath) · Cerebral Vascular Examiner Dua to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avents rasulting in daath) Last Dua to (or as a consequence of): The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760, Dua to (or es a consaguence of) use as t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evallabla prior to completion of cause of daath? should I 24a. Was an autopsy page 2 has 1 ☐ Yas 2 No 1 Yas 2 No certificate or Attending Physician: Be 25. Was case rafarred to medical axaminar? 26. Place of Daath (Chack only one) Hospital: Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 10 1 Yas 2 No □ Inpatiant 2 □ ER/Outpatient 3 □ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28d. Dascribe how injury occurred 27. Mannar of Death 28b Time of Certification: Director: After 1 Naturai 5 Panding 1 ☐ Yas 2 ☐ No daath. invastigation

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State Registrar

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(Check only one)

29b. Signetura end titia of certitia

3 ☐ Suicida

29a. Certifian

6 Could not be daterminad

30. Neme end eddress of person who complated causa of daath (item 23a) (Type, Print) Michael

Sinai Hospital

Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and dua to tha causa(s) and manner as stated

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated.

29c. Licensa number

11931

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Bultimore

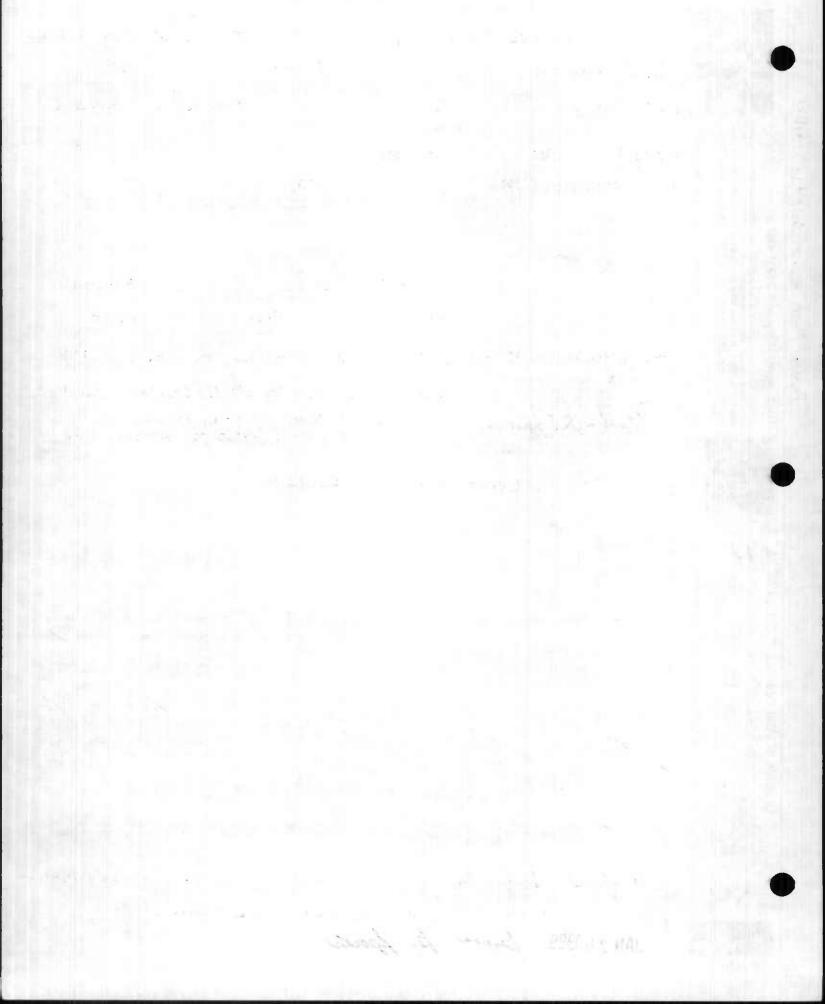
28f. Location (Streat and Number or Rural Route Number, City or Town, Stefa)

29d. Data signed (Month, Day, Year)

January 20, 1999

31. Deta tilad (Month, Day, Year) 12. Ragistrar's Signature JAN 2 6 1999

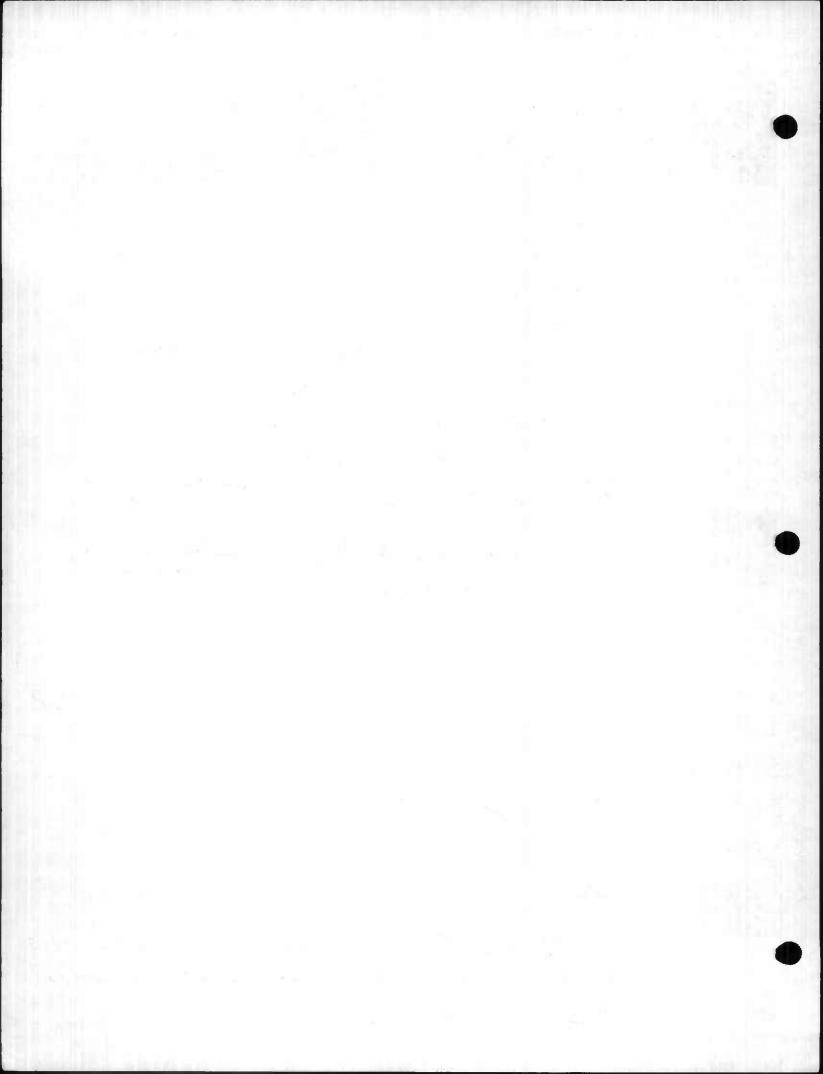
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State of Maryland / Department of Health and Mental Hygiene 9 9 0 1 7 6

					Certificat	e of l	Death		Reg. No.) (1700
Physici	ion	1. Decedent's Name (First, Middle, Last			100			2. Date of De Month	ath Day	Yeer	3. Time of Country
/Medic		Arthur Pa		lerloh	, Jr.			Januar	y 22 .	1999	3:15 P
Examir	ner	4a. Facility Name (If not institution, give				4	4b. City, Town, or I		4c. County		
		Fallston Gener					Fallst			Har:	
Funeral Director		5. Social Security Number 6. Security Number 217-05-7410	7. Age (In	yrs. last birtho	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, De JUNE 9	th y, Year) , 1918	9. Birthp Cour Ma1	piace (Stete or Fore htry) Cyland
and is		10e. State 10b. County	100	c. City, Town o	or Location					1	0d. Inside City Lim
the Marylan 28a-f ahow notified at	Director	Maryland Harfor	·d				Air				1 ☐ Yes 2 🔀 i
23a or	ral Dir	1621 Ruger D	rive	75	10f. Zip	210)15		10g. Citizen of V	JSA	ntry?
Maily fighting 2.1.2.1.3-DOZO d 2 should be filled within 72 hours after death with the Manyland and Mental Hyglene. T is marked other than "natural", or items 23a or 28a-f ahow traumstic event, its Medical Examine mail be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Never Married					Specify	ce · Americ ck, White, y: W]		
n 72 hours "netural",	Be Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. De	ecedent's Usua	al Occupi	ation during most of world)	king	16b. Kind of B	usiness/In	dustry
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d 2 should be filed th and Mental Hyg 7 is marked other traumatic event,	TOB	Arthur Parker	Mundorle	h			Florer	nce Lar	0.0		
shound M	-	19a. Informant's Name/Relationship (Ty			Mailing Address	(Street	end Number or Ru			State, Zip	Code)
and 2 27 is 27 is		Bonnie Helene M	underloh/	wife	1621	Rug	ger Driv	ve Bel	l Air,	MD :	21015
mit. Pages 1 er partment of Heal portant: If Item 2 y injury or other £2.		20a. Method of Disposition	2	Ob. Place of Di				Date	20c. Location -		
Page nent int: If		1 ☐ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Metro (1/25/99	Balt	imo	ce, MD
permit. Pages 1 end 2. Department of Health as Important: If Item 27 is any injury or other travence.		21. Signature of Funeral Service License	WICHOU				ss of Facility Societ erick Ro				
		23a. Pert1. Enter the disease, or complishock, or heert failure. List only or	McDonald cations that caused the							e, I	Approximate
Physician	10	snock, or neert failure. List only or								į	Onset and Death
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sian a		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								1	
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the de	Physician/	Part II. Other signiticant conditions con	tributing to death but no	t resulting in th	ne underlying c	ause give	en in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of dea
thet the de ed by the detached								1 🗆	Yee 2□ No	3 Pro	bebly 4 4 thkno
uires the signed Id be de	d by							24a Was	an eutopsy	24b. W	ere autopsy finding
The law requires thet the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed							perfo	med?	87	alleble prior to mpletion of cause
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n: Ti ficate or. pe		25. Wes case referred to medical					OC Diseased Date	10		1	☐Yes 2☐ No
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g Phys er this eral di	n: To	27. Manner of Death	28a. Date of injury (Month, Dey Yea			8c. Injun Work	4 LI Nursing Fi		how injury occur		//
Attending F r death. Betor: After by the funer	ig ig	1 Natural 5 Pending 2 Accident investigation	(Month, Dey Yea	ar) Inju	M M		k? Yes 2 ☐ No				
可能を	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street, factory) control of the co								per or Rure	Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical C		lician: To the best of my ner: On the basis of examination manner stated.								
athe mple		29b. Signature and title of certifier	1 /		290	. License	e number		29d. Date signe	d (Month,	Dey, Year)
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₽₹₽8 ₽	2	30. Neme and address of person was co	moleted cause of decit	/Itam 22c) /T:-	ma Drint	$\nu_{\mathcal{S}}$	3 6/2		3 7/1.01/	14 2	3,199



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Item 12 Per FH Film G768 2-3-99 rja Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day Month **Physician** Abraham Martin, Jr. 1500 23 1999 Jahuary /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Agnes Hospita n/a If Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1₩ 2□ F 78 249-22-4718 Yrs. Director April 20, 1920 Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or flams 23a or 28a-f ahor the Medical Examiner must be notified at Md. n/a Baltimore Director XXYas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3015 Seamon Avenue 21225 USA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, Whita, atc filed within 72 hours efter Hygiene: other than "natural", or ite YYes PGNo If Yas, Give Year or Dates: 1 Never Married 2 Married aitimore. Marviand 21215-0020 1 Yes 25 No Specify: Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mentel Hygient important: If Itam 27 is marked other the any Injury or other treumatic excessions. Corp. 8th Grade Wire Reeler 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Abraham Martin, Sr. Mary Davis 19a. Informant's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Mattie L. Martin 3015 Seamon Avenue Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 500thar (Specify) Encombment Arbutus Memorial Jan. 29 Baltimore, Md. Park 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signature of Funaral Service License 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Par 1. Enter the disease, or complications that coursed the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feiture. List only one cause on sach line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Heart Failure Congestive YRGAS disease or condition rasulting in death) Examiner Examiner Heart Disease Years Valvular Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown rter Completed by 24b. Wara autopsy findings availabla prior to completion of causa of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 X No 1 ☐ Yes 2 No certificata 25. Wes case refarred to medicat examiner? Be 26. Placa of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) this 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? or Attanding 1 Naturel 5 Pending investigation death. 2 Accident 1 ☐ Yas 2 ☐ No 6 Could not be detarmined n 24 hours after dea we Funeral Director 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, daeth occurred at tha tima, data end placa, and due to the ceuse(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Funs completely fi (Check only one) 29c. License number 29b. Signatura and titla of certifier 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital, Baltimore mD 51 Aghes 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State JAN 26 1999

DHMH 16 Rev 6/95

Registrar

FFD

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THE THE RESERVE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month 8:10 AM William L. Murphy JANUARY 1999 24 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Anne Arundel North Arundel Hospital Glen Burnie If Under 1 Yaar If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Data of Birth (Month, Day, Year) Birthpiace (Stata or Foreign Country) 1⊠M 2□ F Months Days Hours Yrs. 56 219 38 5949 July 10, 1942 Maryland Usuel Rasidence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 21061 U.S. 607 Elizabeth Road 12. Was Decedant Evar in U,S. Armed Forcas? 1∑ Yas 2 □ No If Yas, Giva Year or Detes: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Married 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 N Divorced 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grada completed) (Giva kind of work dona during most of working life. DO NOT usa ratired) Retail Store College (1-4or 5+) 2 years Elementery/Secondary (0-12) Optical Dept. Optician 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Lillian Charles Jesse Murphy 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 607 Elizabeth Road Glen Burnie, Maryland 21061 Linda Fewster 20b. Piece of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition 1 Burial 2 Cremation 3 Ramoval from Stata 1/27/99 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Gonce Funeral Home P.A. ations that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, cause on each line. Baltimore, Md. 21225 23a. Pert1. Enter the disaasil or shock, or haart feilura. Li Approximete Intervel Between Onsat end Deeth Immediata Causa (Final MINITES VENTRICULAR ARRHYTHMIA disease or condition resulting in death) Dua to (or as a consequence of) STROKE WEEKS Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): WEEKS EMBOLISM Due to (or es e consequence of): MONTHS AMIAL ESTILLATION Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Onknown 1 Yes 2 No END STAGE RENAL DISEASE 24b. Wara autopsy findings eveileble prior to complation of cause of death? 24a. Was en autopsy 1 Yas 2 No 1 Yes 2 No 25. Was case referred to medical examinar?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Directo

Funeral

20

Completed

To

Funeral

Director

7 is marked other than "natural", or frams 23a or 28a-f show traumatic avent, the Medical Examinar must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: if item 27 is merked other train. natural', or ther any injury or other traumatic auch.

Maryland 21215-0020

Baltimore,

the Maryland

death

attanding physician and for use as the buriel-tranpaga 2

Examiner Physician/Medical signed by the a Aq Completed has After this certificete eral director. Be 10 Certification: after death

Hospital:

1 Inpatiant

28a. Date of Injury (Month, Day Yaar)

26. Pleca of Daath (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28d. Dascribe how injury occurred 1 ☐ Yas 2 ☐ No

1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding Invastigation 2 Accident 6 Could not be datarmined 3 ☐ Sulcida 4 Homicida 29a. Certifian

(Check only one)

28a. Placa of Injury - At homa, farm, straat, fectory, offica building, atc. (Specify)

 Location (Street and Number or Rurel Routa Number, City or Town, State) 1 👺 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date end plece, and dua to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signatura end titla of certifiar

29c, Licansa number 029296

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

21230

Second in 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

901

2 ER/Outpatient 3 DOA

28b. Tima of

1999 JANUARY

BALTIMONE, MD

State

Medical

GENARD M 31. Date filed (Month, Dey, Year) JAN 25 1999

LOWDER 32. Registrar's Signeture

E. FOUT AVE. parks

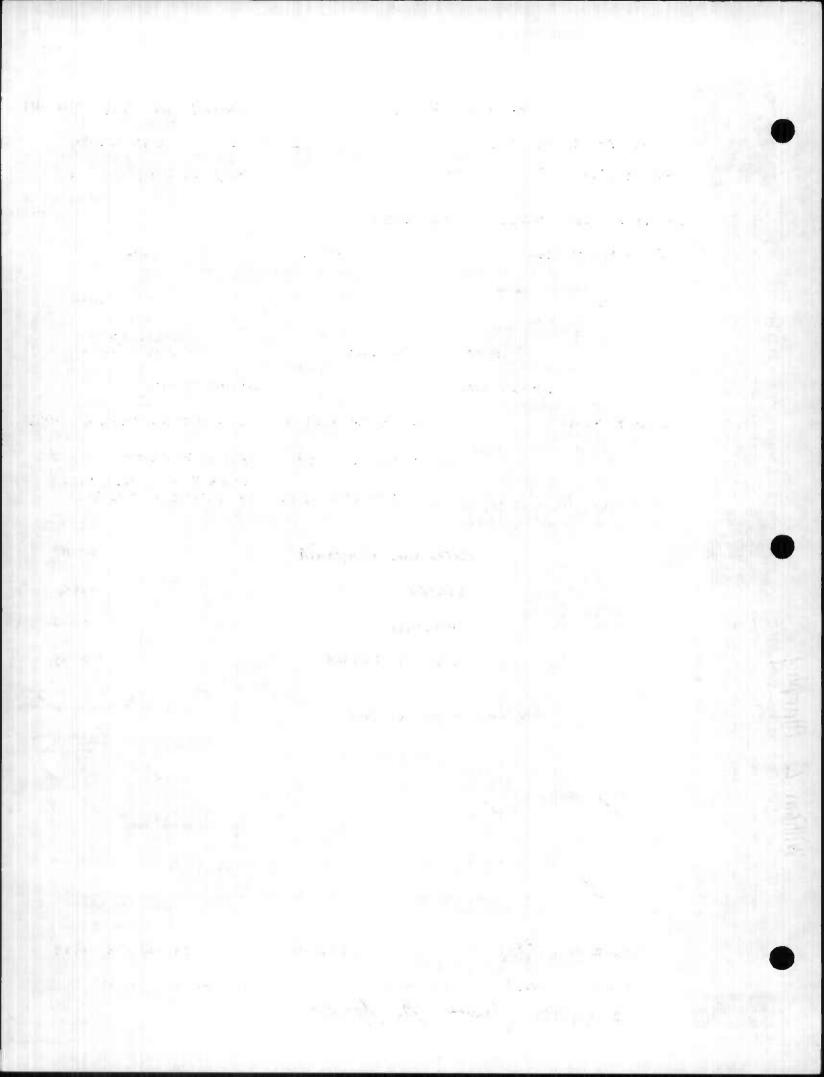
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Registrar

Division of Vital

8 Hospital 24 hours Funeral

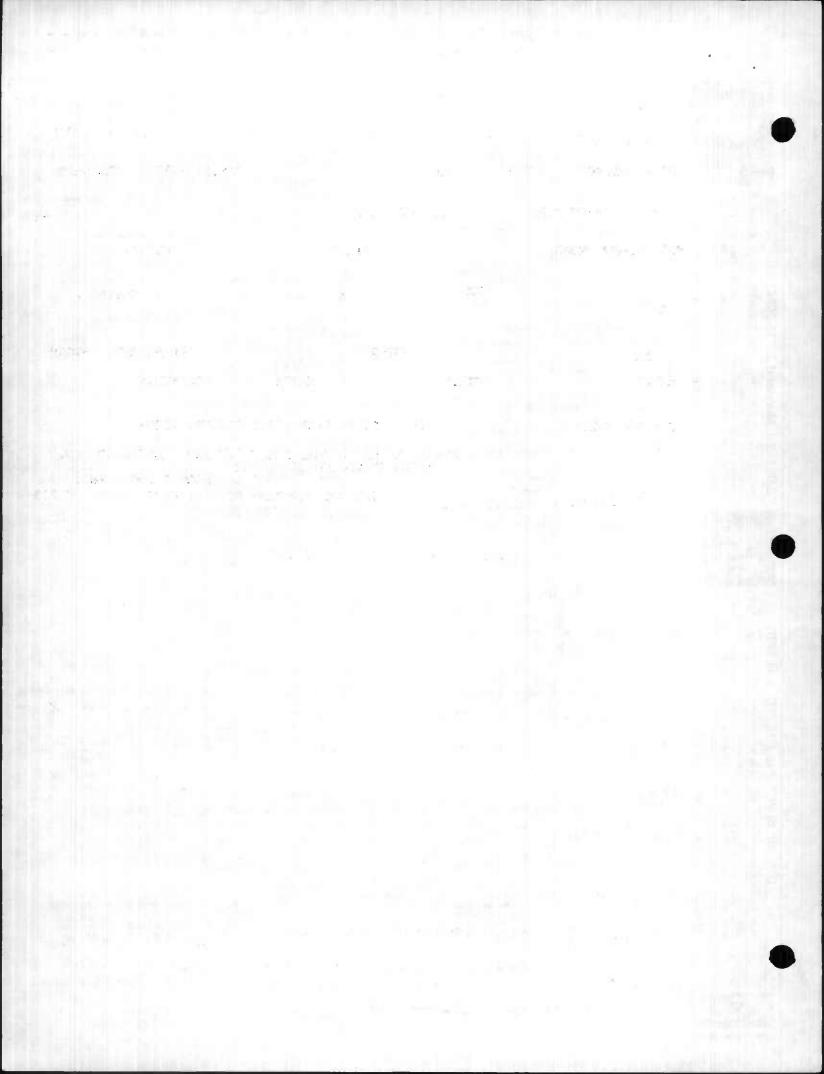
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Nama (First,	Middle, Lest)				tificate c		2. Data of De	Reg. No.	3.	Time of Death
Physician /Medical	ROSALIE		MA	RILS				JANUARY	Day RD /	Year 999	4:00 Am
Examiner	4a Facility Name (If not Ins NORTHWES		treel end number)	0.1						of Death	RE.
uneral irector	5. Social Security Number 215–09–9940		M 2₩ F	e (In yrs. 81	lest birthdey) Yrs.	If Under 1 Ya Months Da			1917	9. Birthplaca Country) DELAW	(State or Foreign ARE
or 28a-f show a rouffed an	Usual Residence of Decederation 10a. State MD BA		E		y, Town or Loc NDALLS						nside City Limits ☐ Yas 2 No
r items 23a or 288-1 si dost maint be notified Funeral Director	10e. Street and Number 4021 ROUEN	ROAD				10f. Zip Cod 21133	9		10g. Citizen of V U.S.A		
Examiner mant be not red at Examiner mant be not red at by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Div] Married	2. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			/as Decedent of Yes, specify C	of Hispanic Origin? uban, Mexican, Pu No Specify:	(Specify Yes or Narto Rican, etc.)	Blac	e - American In kk, White, etc.	dian,
ould be filed within 72 he Mental Hygiene. erked other than "naturatic event, tra Mental To Be Completed	15. De (Specify only Elementary/Secondary (cation complated) College (1-4or 5	i+)	16a. Decedi (Give k life. D	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						
	12 17. Fether's Neme (First, Middle, Last) MEYER AST				DOIL	or .	18. Mother's N	Ieme (First, Middle GC	DEPARTN DEPARTN DEDSTEIN		FORE
	19a. Informent's Name/Re	etionship (Ty)	oe, Print)		19b. Mailing	g Address (Str	eet end Number or	Rurel Route Numi	per, City or Town,	Stete, Zip Cod	9)
int: if item 27 inty or other tre	JAY MARKS/St 20a. Method of Disposition 1 X Burial 2 Crem 4 Donation 5 Ot	ation 3 R	emoval from State	AHA	Place of Disposemetery, creme VAS SHA	sition (Neme of etory or other; ALOM AG	LANE BALT DIOCE B	Date M 1/24/9	20c. Location -		State MD •
Important: any Injury pnce.	21. Signature of Funeral Se	ervica License	7		22.	Nama and Ad	dress of FacilitySC ISTERSTOW	DL LEVINS			21208
vsician ledical aminer Examiner	Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions	a C b	CARC	Due to (d	m A or es a consequ or as a consequ	uence of):	COLON	•			
physicials the burner edical	Sequentially list conditions if any, leading to Immadiac cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):									
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as been s 2 shoult npletec	CORONA	RY	ARTE	124	7	28321	ε.	per	omed?	availab	a prior to tion of cause
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To the Funeral Director: After this centificate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use a Medical Certification: To Be Completed by Physician/M	27. Manner of Death	Pending nvestigation	28a. Date of fnju (Month, De		28b. Time of Injury	28c. f	njury et Work?		how injury occur		
ed in by th	3 ☐ Suicide 6 ☐ 6 4 ☐ Homicide	28a. Place of Inj building, etc	Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)			28f. Location (Streef and Number or Rurel Route Number, City or Town, State)					
he Funera pletely filli edical (Icien: To the best of er: On the basis of and manner sta	examina					, date and place,	and dua to the	cause(s)
To com	29b. Signature and title of	certifler k	touse q	PHYS	MAIN	0	anse number 42723 45 fox LTIMOR	-	29d. Date signe	23 RD	Year) 1999
			mpleted cause of d	noth (line	- 00-1 /Tun- F	C.C. Heins	1. 6 Inc	- 00 C	IREAM	2 M C	0.4

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death JART 23 **Physician** RAYMOND 1999 MITTENTHAL 11AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 16 WARREN PARK DRIVE APT. B-4 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Yeer) 9. Birthplace (Stete or Foreign **Funeral** X M 2□ F Days Months Hours ALABAMA Yrs 217-14-2933 89 **Director** AUG.16 1909 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No MD BALTIMORE PIKESVILLE Directo 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 16 WARREN PARK DRIVE APT. B-4 21208 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Yes 2 NoWW II WHITE 1 ☐ Yes 💥 No Specify: Specify: à 3 Widowed 4 Divorced Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) SALES MENS CLOTHING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WETNBERG SAMUEL MITTENTHAL TILLIE 10 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a, Informant's Name/Reletionship (Type, Print) 1 POMONA EAST, APT. 411 BALTIMORE, MD. 21208 MILDRED LAUFE/ SISTER 20b. Place of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, State BETH TFILOH "CONG." CEM. 1 Burial 2 □ Cremetion 3 □ Removal from State JAN. 24/99 BALTIMORE, MD. permit. Page Depertment of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility SOL LEVINSIN & BROS. INC. 1 21208 8900 REISTERSTOWN ROAD, PIKESVILLE MD. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear feilure. List only one cause on each line. Approximeta Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel mous Cell Carcho disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 6 To 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury at Work? 28b. Time of Certification: L'ENaturel 5 Pending 1 Yes 2 No 2 ☐ Accident Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner es steled.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29e. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Hospital 24 hours To the Within 2

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Hygiene.

Pages 1 end 2 should be fill ment of Health and Mentel Hent: If item 27 is marked oth jury or other traumatic even

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P.O. Box 68760

Division of Vital Records.

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altimore, Maryland 21215-0020

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

State Registrar 31. Date filed (Month, Dey, Year)

ECD o

NUD 32. Registrar's Signature

30. Name and eddress of person wto completed cause of death (Item 23a) (Type, Print)

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Owings Mills.

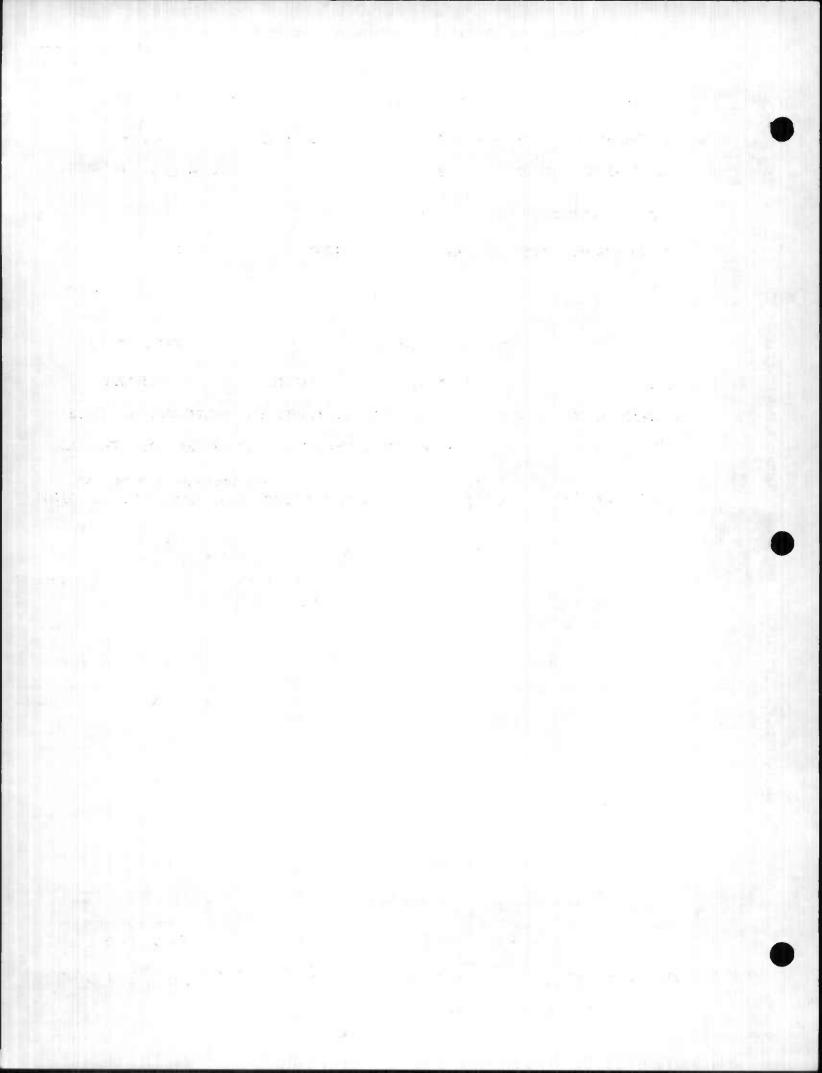
Suite 240

23 Crossraads

Maryland

JAN 26 1999

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 **Physician** JANUARY 1999 9:32 Am Marquerite R. Needer /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL CENTER HAR BOR BALTIMORE MARGUERITE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 20 F Yes. 215 05 9010 Jan. 14, 1906 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show treumstic event, the Medical Examinar must be notified at 1X Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 825 Freeman Street 21225 U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 6th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) leges 1 and 2 should be fill out of Health and Mental Hi t: If frem 27 Ia marked oth y or other treumatic even Jennie Regina Berger 山 Sigmund Joseph Reckline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lilly Woodward / sister 106 E. Hamburg Street Baltimore, Maryland 21230 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges 1
Department of H
Important: If ites
eny injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Memorial Park 1/23/99 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 romerousely 23a. Part1. Enter the disease, periplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death **Physician** PNEUMONIA Immediata Cause (Final disease or condition resulting in death) /Medical WEEKI Examiner Due to (or as a consequence of): Examine URUSGPSIS WEEKS physician and the burief-transit certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 20 No edical Certification: To this 27. Manner of Deatl 28c. Injury at Work? 28d. Describe how injury occurred I or Attending Patter death. Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

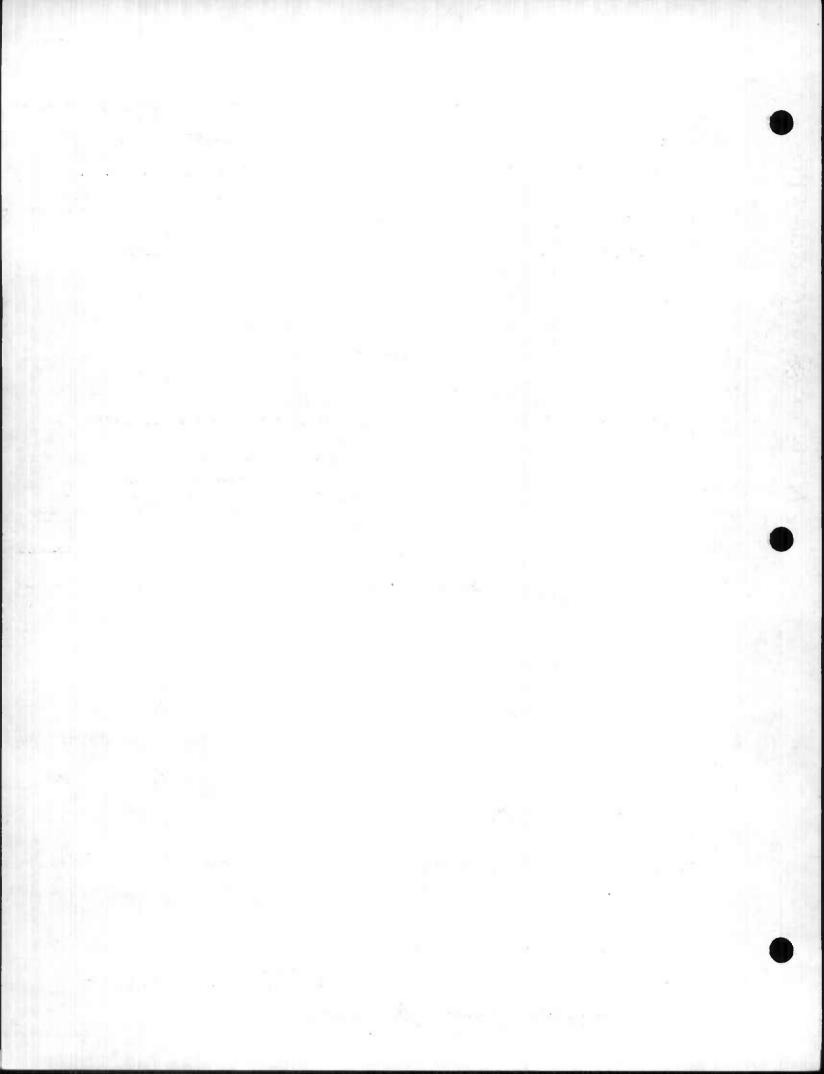
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certile 12797 INTERN JANUARY 20 completed cause of death (Nem 23a) (Type, Print) 300 | SOUTH HANDVER STREET 30. Name and address of person 1 GYAW SHWE MRA BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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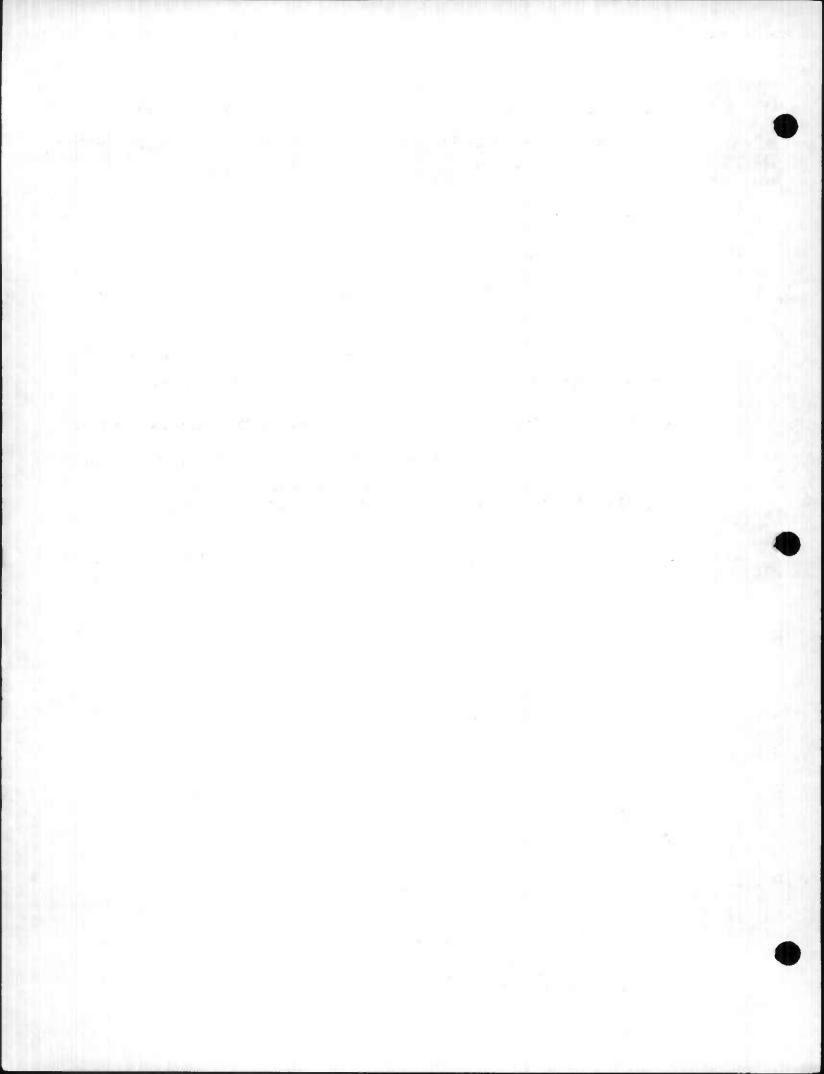
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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Year L. Mary 0' Hara January 20, 1999 10:15 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Health Care Rossville Rossville Baltimore County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 4, 1915 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2☑F 212 16 8166 83 Yrs Director Usual Residence of Decedent the Merylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A 1 Yes 2 □ No Director **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Pages 1 and 2 should be filed within 72 hours efter deeth with nent of Health end Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23s or inty or other traumatic event, the Medical Examine must be in 3939 Roland Avenue 21211 U.S.A. Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 22☐ No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Orlgln? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Married 2 Married Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Grocery Store Head Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Nicholas Bychich Ella Kilrov 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Robert O'Hara 4 PIne Mont Place Apt 1B, Baltimore, MD 21236
pe of Disposition (Neme of Date 20c. Location - City or Town, State 20b. Place of Disposition (Neme of cematery, cremetory or other piece) 20a. Mathod of Disposition permit. Pages Department of Important: If It any injury or c 1 Durlal 2 Cramation 3 Removal from Stata
4 Donation 3 Other (Spacify) Gardens of Faith 1/25/99 Fullerton, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility Burgee-Henss Funeral Home, P.A. 23a. Part 1. Ent fifthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ward failure. List only one ceuse on each line. **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Ovarian Canter with metastares Examiner Due to (or as a consequence of): Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. Due to (or as a consequence of) 98 esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown malnutrition Records, þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: AV Nursing Home 5 Rasidenca 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 20 No Certification: To After this 27. Menner of Death 28d. Describe how injury occurred Division or Attending 5 Pending Investigation ours efter deeth. herai Director: Aft filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide To the Hospital c within 24 hours of To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated.

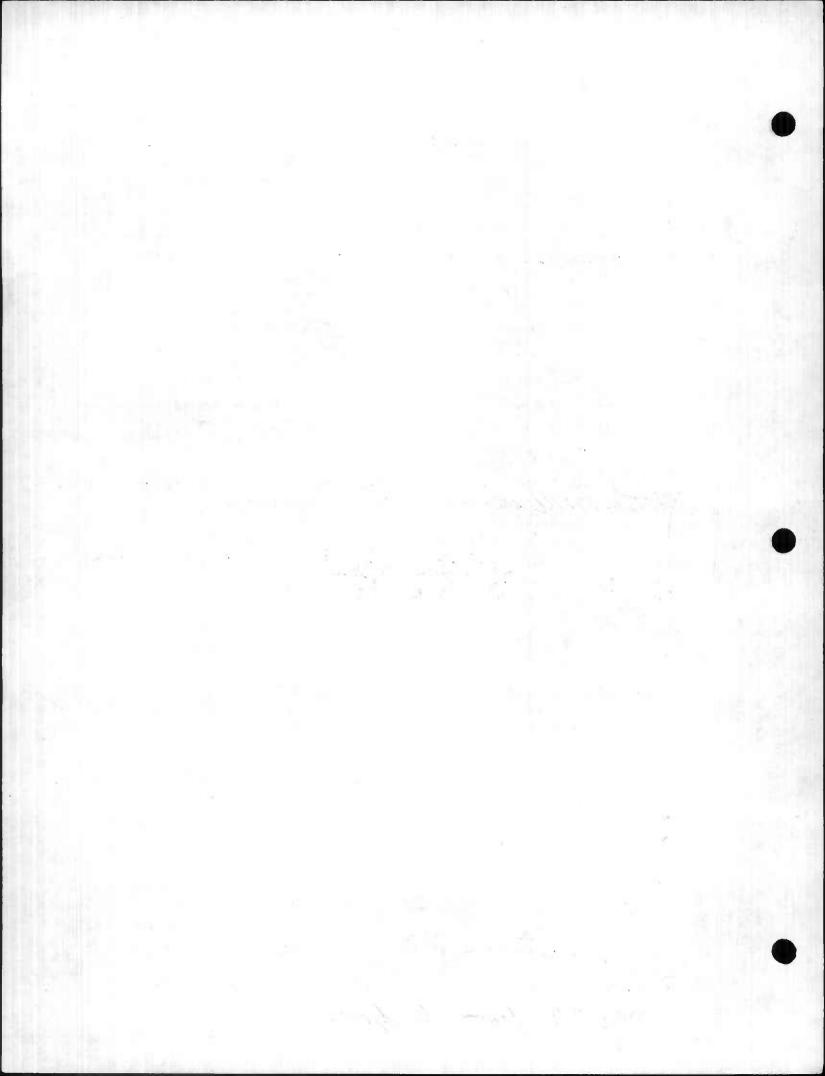
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29d. Date signad (Month, Dey, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Jones Md 21204 7600 Opl Suite 203 Drive ors 31. Date filed (Month, Dey, Year) 32. Registras Signature State JAN 26 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

D. Okon			Certifica	ate of	Death	100.10	Reg. No.			
Physician /Medical	1. Decedent's Name (First, Middle Jim D. Okon					2. Dete of Do Month Janua:	Dey ry 08, 1	Year 999	3. Time of Death 1:05 P.M.	
Examiner	4a Facility Name (If not institution		Location of Dea							
Funeral	5. Social Security Number	t Road, Apartme 6. Sex 7. Age (In yrs XXM 2DF 62		der 1 Year	Adelph: If Under 24 Hrs. Hours Min.	Prince George's 8. Date of Birth June 11, 1936 9. Birthplace (State or I				
Director	Unknown Usual Residence of Decedent		110.			Touric 1	1, 1930	unkn	IOWN	
And Mand	10s. State 10b. County	10c. C	ity, Town or Location					10	d. Inside City Limits	
th with the Maryla 23s or 28s-f sho ust be notified at 181 Director	MD Prin		10g. Citizen of	What Countr	Yes 2 No					
The state of		D-1 3-1 1500		Zip Code						
har death in the same same same same same same same sam	44 44 3 4 84 4	Rd., Apt. 1502	J.S. 13. Was De	2078 cedent of H	lispanic Origin? (S	pecify Yes or N	USA 0- 14. Rad	e - America	n Indien,	
ar, or har Examine by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	7 811100 1 010001	II Yes, s	pecify Cube	an, Mexican, Puert Specify:	o Rican, etc.)	Ble	ck, White, et y: Bla		
ted to	15. Decedent		16a. Decedent's U	suel Occup	pation		16b. Kind of B	usiness/Indu	ustry	
n, the Medical Completed	(Specify only highes Elementary/Secondary (0-12)	Grade completed) College (1-4or 5+)	(Give kind of life. DO NOT	work done Tuse retired	during most of word)	rking				
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To B		unknown				unknown				
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alth a 27 is 27 is	Det. Curtis, 118	3(301-772-4925)	Prince G	eorge	's Count	v Polic	e Depart	ment		
ary or othe	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (Sp	3 □Removel Irom State	Place of Disposition (I cemetery, cremetory of	Vame of		Date	20c. Location		vn, Stete	
Departri Importa any inju poce	21. Signature of Fundral Service L	, 655 W. Baltimore Street d 21201								
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physician and the burlet-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or es a consequence o							
eteched for use as Physician/Me		d								
yel yel	Part II. Other significant condition	s contributing to death but not re-	sulting in tha undarlyin	g cause giv	ven in Pert I.	23b. Did	tobacco use co	intribute to	the cause of death?	
igned by the attending be deteched for use at by Physician/Me						1	Yes 2□ No	3 Probi	ably 4 Unknown	
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Com						112	Yes 2□No	10	Yes 2□ No	
this certificate ral director, peg	25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No	Hospitel: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA Oth	26. Place of Dea ner: 4□ Nursing H		ona) idence 6 □Oth	ner (Specify))	
or deeth. Sctor: After the by the funeral Ification:	27. Manner of Death 1 Manural 2 Accident 5 Pending investig	ition	28a. Date of Injury (Month, Day Year) 28b. Tima of Injury M 28c. Injury at Work?				28d. Describe how injury occurred			
Pin Dire	3 Suicide 6 Could n 4 Homicide detarmin	286. Place of Injury - At r	Place of Injury - At home, Ierm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural R City or Town, Stata)						Route Number,	
within 24 hours To the Funeral completely filled		Physician: To the best of my know examiner: On the besis of axaminand manner steted.								
within comple	29b. Signature and title of certifier		11	29c. Licens	se number		29d. Date signe	d (Month, D	Day, Year)	
	No Name and address	ulaner,	1V(D.	(O.C.M.E.		January	09, 1	1999	
2 36.2	30. Name and address of person	Pestaner	111	Penn	Street,	Baltim	ore, Mar	yland	21201	
State Registrar	31. Date liled (Month) Day, Year)	32. Registrer's Sign	eture Loc	. 1/1						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 10:17am 1 99 Ruthc, Priore 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Hospital Baltimore Maryland treneral If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Steta or Foreign Country) 6. Sex Months Days Hours 1□M 2□ F Yrs 213-14-5986 78 04/02/1920 Massachusetts Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ¥ Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 S. Athol Avenue 21229 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian. Black, White, atc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th Cosmetics Sales 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) E. Colgan Hillman Genevieve Grygiel 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) John R. Lansinger/Son 6508 Pampano Dr. Glen Burnie, MD 21061 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burlat 2 □ Cremation 3 □ Removal from State Meadowridge Cemetery 01/28/99 Elkridge 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 5311 Edmondson Ave. Baltimore, MD 21229 Part . Enter the disease of complications that caused the death. Do not enter shock or heart failure Les only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EUMONIA EPSIS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): that initiated events rasulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of peath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Straaf and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one)

The lew requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: deeth. efter To the Hospital or A within 24 hours efter To the Funerel Directompletely filled in by

Physician

/Medical

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Funeral

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Completed

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Examiner

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic avent, the Medical Emritor must be notified at once.

Physician

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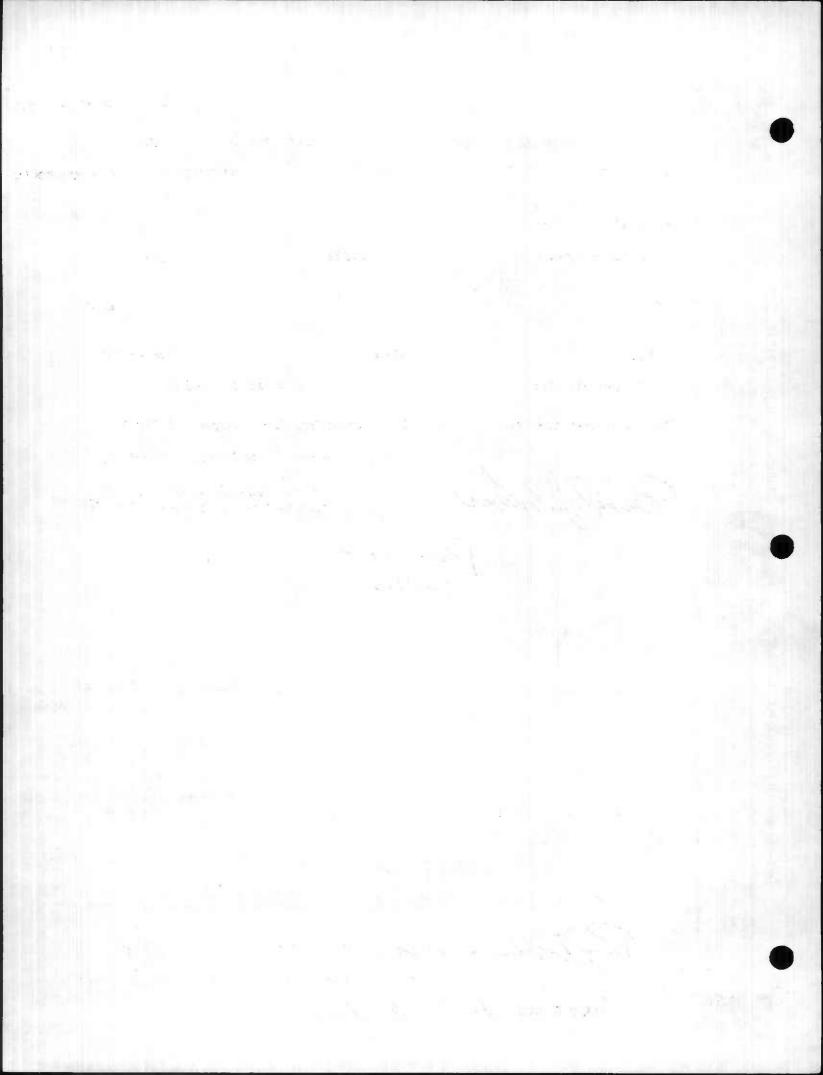
31. Dete filed (Month, Day, Year) JAN26 1999

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
TRARE IN ISAME. M.D. YO Maryland General Hospital. 32. Registrar's Signature

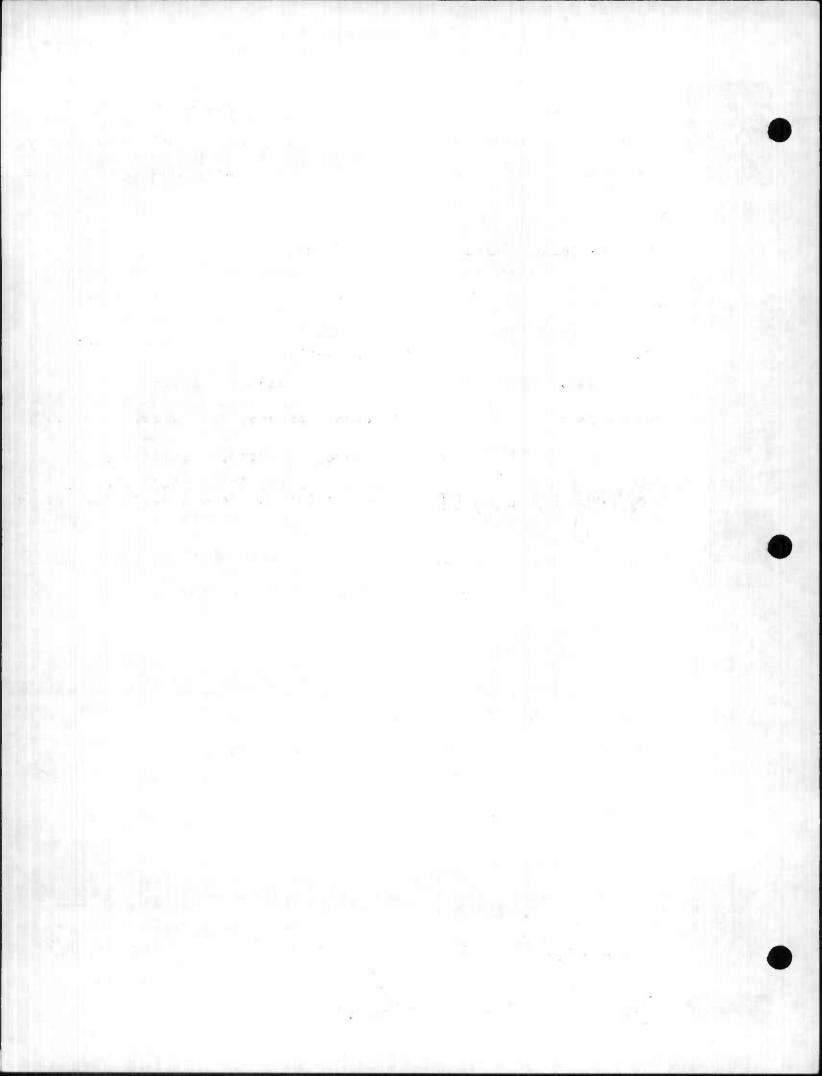
29d. Date signed (Month, Day, Year)

Registrar



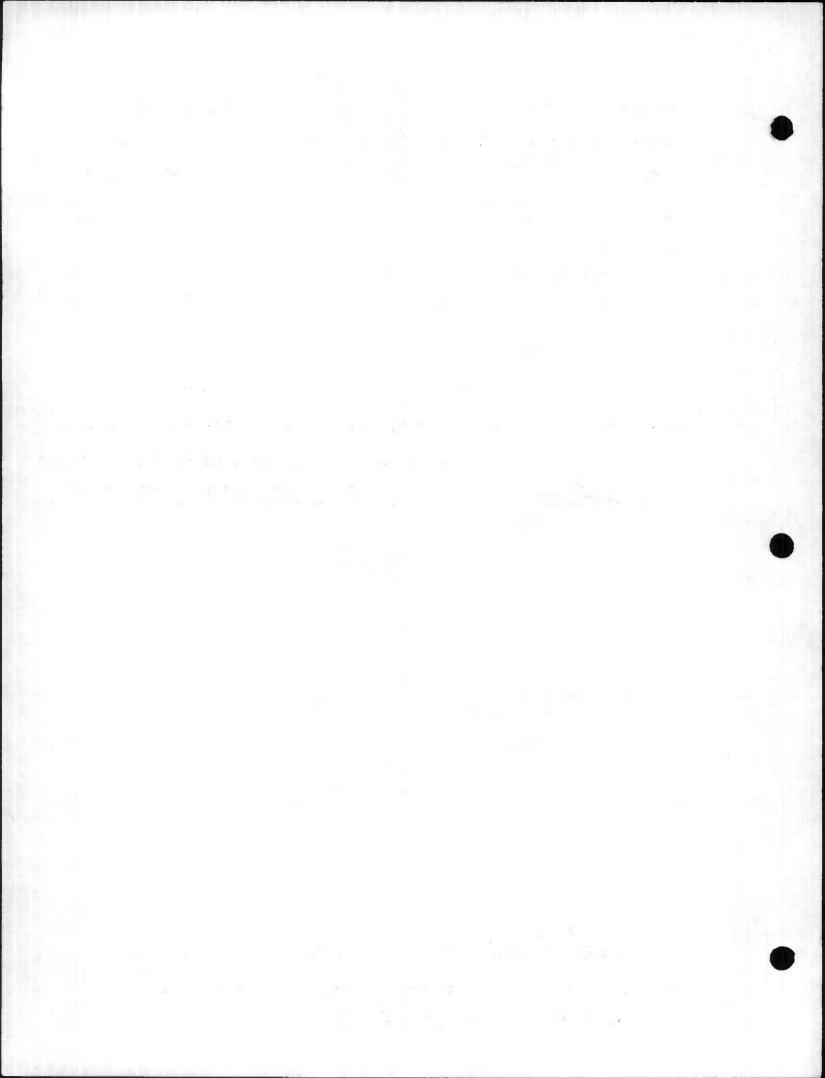
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month **Physician** MODE REBECCA 1888 2 mally /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner MODICIL CEN TOR BOTTMORD 41 BURTY CITY BALTIMORE | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 2 / 3 1 / 1 9 0 8 If Under 1 Year 9. Birthplace (State or Foreign Country)
N. Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 23 F 90 Yrs. 213-10-6467 Director Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at MD N/A BALTIMORE 1 X Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21207 3912 Dorchester Road U.S.A. Funerai 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 ☐ Yes 2 🛣 No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☑ Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within end Mental Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Restaurant Entrepreneur 8th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Watt Walker Jeanette White 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Walker 4543 Finney Avenue, Baltimore, MD 21215 Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 10 1 ₭ Buriel 2 Cremetion 3 Removel from Stete = 8 permit. Page Department of Important: If eny Injury or once. Woodlawn Cemetery 1/29/99 Baltimore, 4 □ Dogation 5 □ Other (Specify) 22. Name and Address of Facility Willie SON E. HOWELL HOME, P. A 4600 LIBERTY HEIGHTS AVE., BALTO., MD21207 or complications that can'ted the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, lat only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Deci DENT CEREBRO VAS CULAR Examiner Due to (or as a consequence of): Examiner FIBRILLDTION DIRIAL 2H20MC physician and the burial-transit the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Box 68760. Physician/Medicai Due to (or es e consequence of): 80 USe o Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? the signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 118125 CONGESTIVE FAILURE - ALZIEIMERS Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy Completed ASPIRATION' PNEW MONIA . ARTONIS EJULEO, 2001 certificate hes t 1 Yes 2 No 2 1 No D1587156 HYPERIENSINE Division of Vital Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) 1 Inpatient To 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death. 2 Accident ofter death Director: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) in 24 hour.
The Funeral Direction of the filled in by 4 Homleide ò 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the cont 29a. Certifier Medicai (Check only one) r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. To the F within 2 To the F complet 29b. Signature end title of ce 29c. License number 29d. Date signed (Month, Day, Year) Morrie D19017 1999 30. Neme and address of person with completed ceuse of death (Item 23a) (Type, Print) Coarer LIBERTY COPRED NUNICH ELDYO 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 6 1999 Registrar



Please Type or Print in Black Indelibie ink. Assure All Copies Are Degible

	-	1. Decedent's Name (First, I	liddle, La	st)		001	tificate of	Dodin	2. Date of De	Reg. No.		3. Time of Dea
Physici		Porchea Isob	ell l	Petersen					Month Januar	Dev	Year 999	23:21
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uneral irector		5. Social Security Number NONE	6. S	ex 7. Ag □ M 2 1 F	ge (In yrs. iasi	t birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di 12/17	th ay Year) 1998	9. Birthp Coun Mar	iaca (State or For try) yland
how		Usual Residence of Deceder 10a. State 10b. Co			10c. City, T	own or Loc	eation				1	0d. Inside City Li
T De Di	jo	MD	N/A	1	Balt	imore	2					XX Yes 2
23a or 28	Funeral Director	10e. Street and Number 7501 Maury R	oad				10f. Zip Code 212	44		10g. Citizen of W	/hat Coun	itry?
al', or items : Examiner m	by Funer	11. Marital Status N/A 1 Never Married 2 3 Widowed 4 Divo	Merried	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		If	/as Decedent of I Yes, specity Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		k, White,	an Indian, etc. ack
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sumeti sumeti	-	19a. Informant's Neme/Rela	tionship (Type, Print)		19b. Mailine	Address (Street	and Number or Rui				Code) 0 + 0
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Francis Leslie Pollard Jr. January 1999 7:00 A. M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 3103 Beverly Road N/A 8. Date of Birth (Month, Day, Year) Dec. 31, 1 5. Social Security Number If Under If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours 220-50-2630 Maryland 52 1946 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? 3103 Beverly Road 21214 U. S. A. 14. Raca - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 1 ☐ Yes 2 No Spacify: 3 Widowed 4 Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Chief Inspector State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Sumame) Francis L. Pollard Sr. Gloria M. Wiedeck 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) Gloria M. Pollard (Mother) 3103 Beverly Road, Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State /27/99 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Garden's Timonium, Maryland 21. Signature of Funaral Service Licensea 22. Name and Address of Facility Schimunek Funeral Home Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset end Death Immediate Cause (Final disease or condition resulting in death) equence of): 2+1c Nephrapathy equanca of): 2+es mellitus Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a conseque Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 20 No 25. Was casa raferred to madical 26. Piace of Death (Check only one) examinar' 1 Yes 2 No Othar: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Othar (Specify) 28a. Data of Injury (Month, Day Year) 27. Manpar of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 1\ Naturai 2 \ Accident 5 Panding investigation 1 Yes 2 No

P.O. Box 68760, The law requires that the deeth certificete bethe use as Division of Vital Records,

certificate

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Physician

/Medical

Examiner

Director

Funeral

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Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Med as Examiner mast be notified at

Peges 1 and 2 should be filled within 72 hours after nent of Health end Mental Hygiene.

Int: If Item 27 is marked other than "natural", or ite

Department of Health e Important: If Item 27 is any Injury or other tra

Physician

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

death

Examiner tal or Attending Physician: The sefter death.

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4 - Homicide

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State Registrar

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. and title of certifier 30. Name and

6 Could not be

m 23a) (Type, Print)

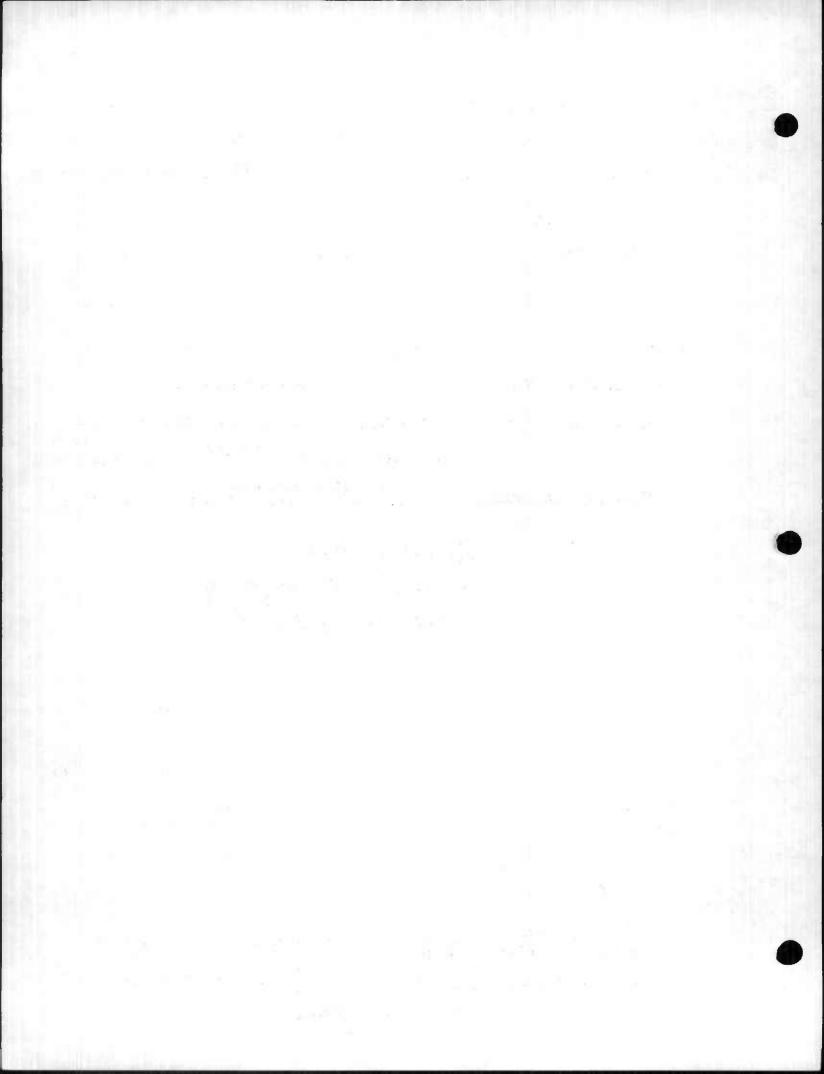
28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

1 Certifying Phyalcien: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and manner as atated.

Location (Street and Number or Rural Route Number, City or Town, Stata)

lowson Md.

32. Registrant Signature 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Neme (First, Middle, Last) 2. Dete of Daath 3. Time of Death Month Voer Arthur Odenweller Parks 1315 Janvan 1999 20 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Dewh 4c. County of Deeth Augsburg Home Baltimore Baltimore 5. Sociel Security Number 6. Sex 1 X M 2 ☐ F If Under 1 Year If Undar 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 352-12-5263 86 Yrs Illinois May 1, 1912 Usuel Residenca of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 N No Maryland Prince Georges Temple Hills 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5708 Janice Lane 20748 United States 12. Wes Decadent Ever in U,S. Armed Forcas? 1 M Yes 2 □ No if Yes, Give Yaar or Dates: WWII 11. Maritel Stetus Was Decedent of Hispenic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American indlen, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yas 2 No Specify: 3 X Widowed 4 □ Divorced Specify: WWIT White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry College (1-4or 5+) Elamentery/Secondary (0-12) naval research federal government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) Franklin Thomas Parks Elsie Odenweller 19e. informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Streat and Number or Rural Routa Number, City or Town, Stete, Zip Code) Alice Lange/daughter 512 Dunkirk Rd. Baltimore, MD 21212 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata Date 1 Burlel 2 X Cramation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Crematory 1/23/99 Baltimore, Maryland 21. Signature of Funerei Service Licensee 22. Name end Address of Fecility The SEFELD 6500 YORKRD. 21212 234. Pm1. Entar tha disease, or complications that causad tha deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, mock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final Drostate metastatic Cance disaesa or condition resulting in deeth) 415 Due to (or es e consequença of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Due to (or es e consequença of): Dua to (or as e consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 | Yes 2 | No 3 | Probably 4 TUnknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy parformed? 1 Tyes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicida 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1166 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29e. Certifier (Check only one)

Physician /Medical **Examiner** The law requires that the death certificate be Box 68760. P.O. Division of Vital Records. or Attending Physician: Hospital To the within 2

Physician

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Examiner

Funeral

Director

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DHMH 16 Rev 6/95

Tibell 31. Dete filed (Month, Dey, Year) State Registrar

29b. Signature and title of certifier



30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Park Heights Ave

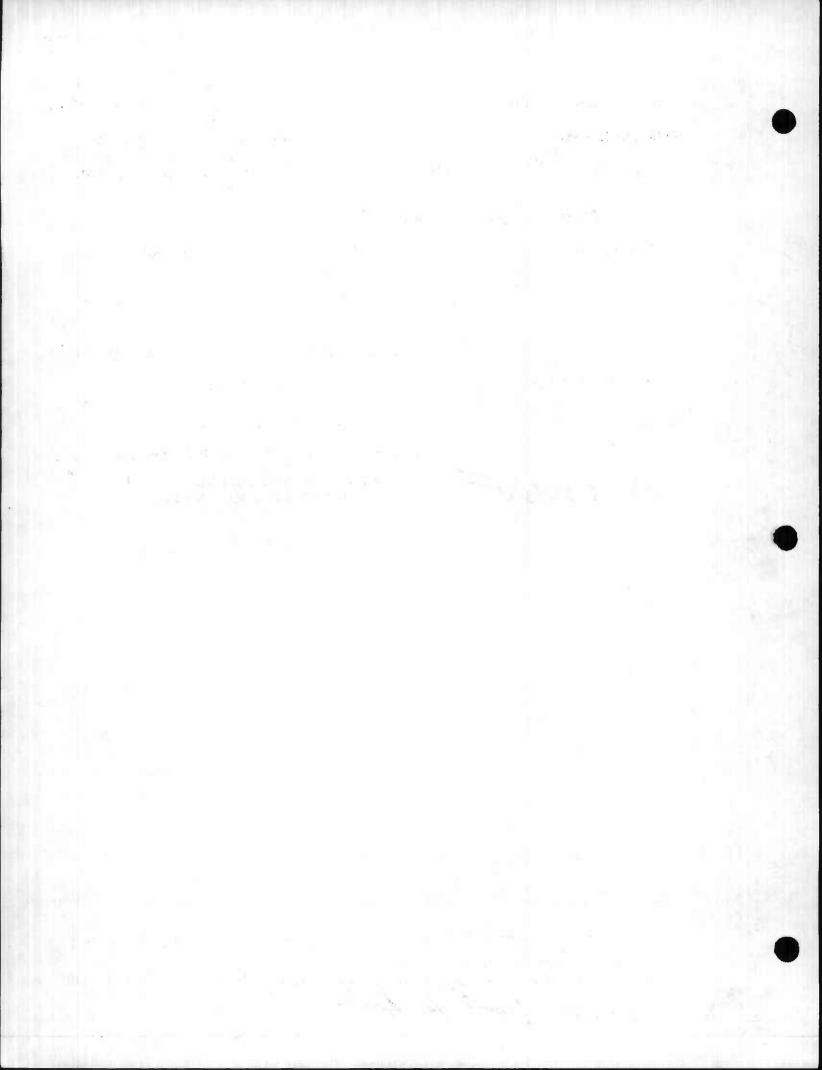
29c. License number

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29d. Date signed (Month, Dey, Year)

Baltme

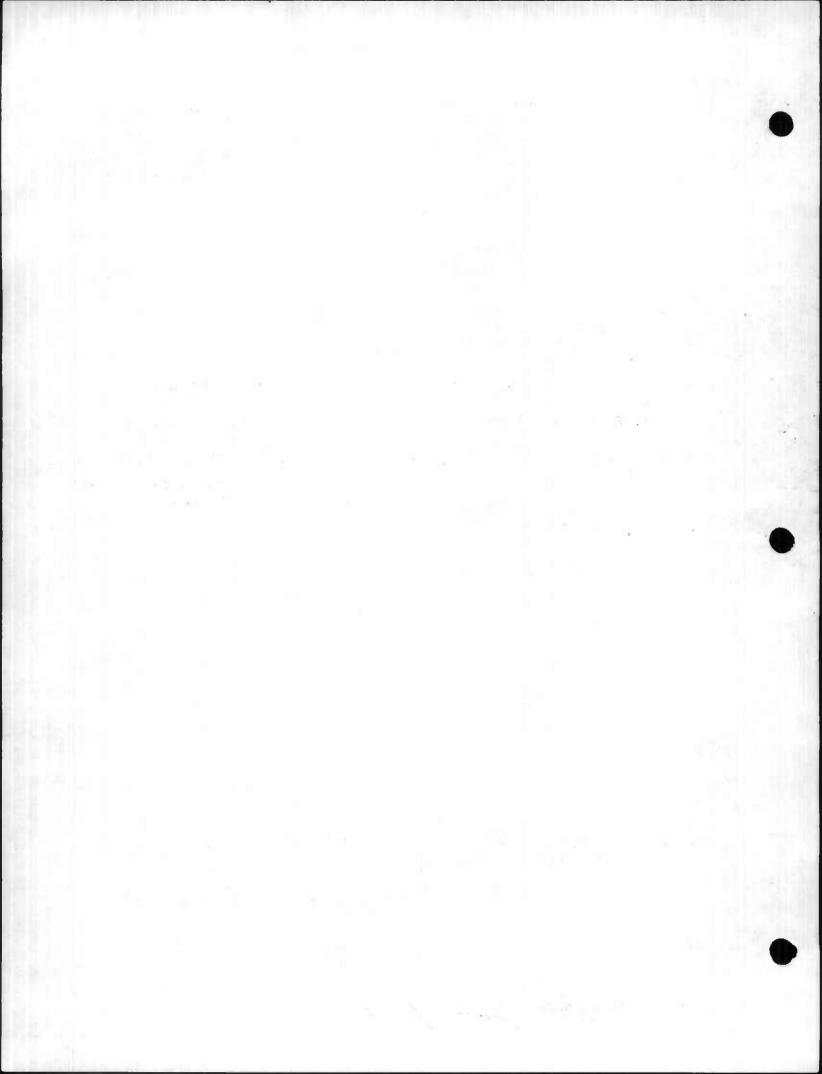


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Wanda Fay Pollay 11:38 A.M. 1999 JANUARY /Medical 4c. County of Deeth 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death **Examiner** SqUARE Rosedale If Under 24 Hrs. 8. Det FRANKLIN DILA BALTIMORE 1405 Ce 8. Dete of Birth (Month, Dey, Year)
July 25, 1938 al Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys 1 □ M 2X F 200 28 5133 Yes 60 Director Pennsylvania Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits herra 23a or 28a-f show ner must be notified at Maryland Baltimore 1 ☐ Yes 2 No Baltimore Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 205 Mulberry Lane 21220 Funeral U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 No If Yes, Give natural', or 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12th end Mental Hygi 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Elizabeth Hall Francis Yeager 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Haalth Important: If Item 27 I Harry R. Pollay / Husband 205 Mulberry Lane Baltimore, Maryland 21220 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 █ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 1/22/99 Glen Burnie, Maryland 21. Signeture of Funeral Servica Licanses 22. Name and Address of Facility Gonce Funeral Home P.A. menousky 4001 Ritchie Highway Baltimore, Md. 21225 Part 1. Enter the disease, or common etions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** /Medical tmmediate Cause (Finel ARRHY MMIA HOUR disease or condition resulting in deeth) Examiner Que to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) usa P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were eutopsy findings svaiteble prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed 1 ☐ Yes 2 No 25. Wes case referred to medical axaminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2N No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: or Attending 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 Homicide 24 hours Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pteca, end due to the cause(s) end menner es stated.

Medical Examtner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) and menner stated. edical 29e. Certifier To the Hosp within 24 hor To the Fune complately fi (Check only one) 29b. Signeture and title of certified 29c. License number 29d, Dete signed (Month, Day, Year) imo. 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) FRANKlin Square DR. BALTIMORE, MARYLAND 9000 DR. LAURIE HA
31. Date filed (Month, Day, Year)
JAN 2 5 1999 HARRI 32, Registrer's Signeture

Registrar **DHMH 16 Rev 6/95**

State



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Pricecarter Janory TONN Wesley 0012 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death university Baltimore Of Maculand Medical Sistem

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Wonths Days Baltimore City 5. Social Security Number If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Dey, Yeer) Jan. 7, 1999 9. Birthplace (Steta or Foreign Hours Yrs. Maryland none Usual Residenca of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore County 1 Tyes 2 TXNo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 745 Howard Road 21208 U.S.A. 12. Was Decedent Evar in U,S Armed Forces? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11 Marital Statue 1 Navar Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede com 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry complated) Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) John Carter Laura B. Price 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 745 Howard Road, Baltimore, Maryland 21208 Laura B. Price/mother 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of America Service Ligensa S. Wade, Director State and Address of Facility Board 655 W. Baltimore Street Baltimore, Maryland 21201 Part1. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line. Approximata Intarval Between Onset and Deeth Immediate Cause (Final . Persistent Fetal Circulation disease or condition resulting in death) Severe Respiratory Distress Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last xtreme Frematurity Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Hypo volemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? anemia 25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dev Year) 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 D Homicide

Examiner The law requires that the death certificate be executed the bunal-transit P.O. Box 68760. Records, be d cartificate Division of Vital or Attending Physician: this funeral After To the Hospital or Attendir within 24 hours aftar death. To the Funeral Director: Al filled in by the

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21215-0020

Baltimore, Maryland

Director

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Examiner Certification: To Medicai

29a. Certifier

State Registrar

WINSTON 31. Date filed (Month, Dev. Year) JAN 25

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) manimim, M.D. Druision of Neonatology, umms 205 Grunest 32. Registrar's Signatura

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

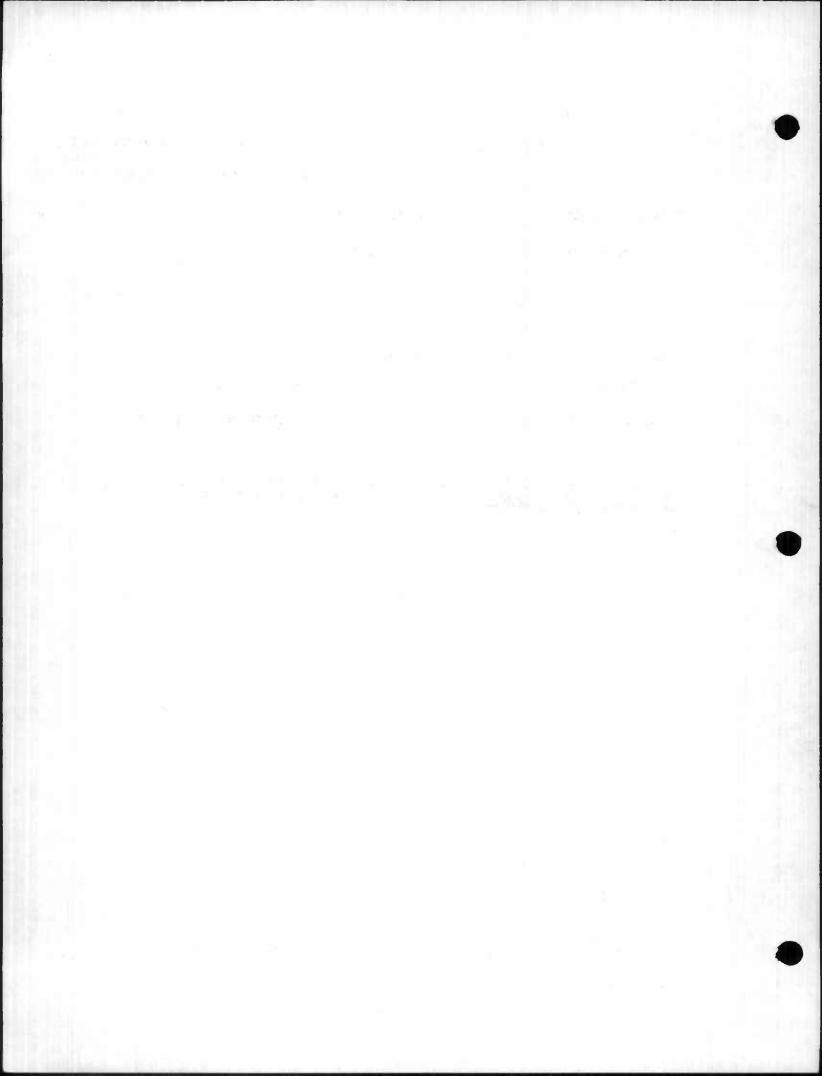
29c. Licansa numbar

D52159

29d. Data signad (Month, Dey, Year)

January 11, 1999

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Deeth 3. Tima of Death January 24, 1999 8:52am Charles Alexander Robinson Sr. 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva straet and number) 4c. County of Deeth 5323 Maple Avenue Baltimore N/A 8. Date of Birth (Month, Day, Year) Sept 19,1931 5. Sociel Security Number 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days 10XM 20 F Hours Maryland 213-28-7199 67 Usuel Residence of Decedent 10d. Inside City Limits 10a Steta 10c. City, Town or Location 10b. County N/A MdBaltimore 1 Yas 2 No 10e. Streef and Number 10f. Zip Code 10g. Citizen of Whet Country? 5323 Maple Avenue 21215 USA 12. Was Dacedant Ever In U.S. Armed Forces? 8/4/52 1 ﷺ es 2 □ N8 If Yes, Give Yeer or Datas: Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Black, Whifa, etc. 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decadent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Engineer Stee1 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Neme (First, Middle, Last) James Robinson Ruth Robinson (Robinson) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Tyree M. Robinson (Wife) 5323 Maple Avenue Baltimore, Maryland 21215 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, crematory or other placa) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from Stete Owings Mills, Md Garrison Forest Vet Cem 1/28/99 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Caple Funeral Service of Funeral Service US 5502 Winner Avenue Baltimore, Maryland 21215 and 1. Enter the disease or complications that causad the death. Do not enter the mode of dying, such as cardiec or respiretory errest, nock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disaasa or condition resulting in death)

Physician /Medical Examiner

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Director

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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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24b. Were eutopsy findings available prior to completion of causa of death? 24a. Wes en eutopsy performad?

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Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpafiant 2 ER/Outpatient 3 DOA 27. Menne of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury of Work?

Neturel 5 Pending 1 Tes 2 No investigation 2 Accident

3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) and manner stated. 29a. Certifier

29c. License number

29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier

ath (Item 23e) (Type, Print) 30. Neme end eddress of person who 350

State Registrar

31. Dete filed (Month, Dey, Year) JAN 26 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Anthony J. Reda January 23, 1999 06:19 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Johns Hopkins Bayview Medical Center Baltimore n/a if Under 1 Year Hours Min. 8. Date of Birth (Month, Dev. Yee 7–16–1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Months 1**™**M 2□ F 80 217-07-1223 Yrs Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD n/a Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3408 Esther Place 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? **Army** 1 X Yes 2 □ No If Yes, Give 3-1943 Year or Dates: 12-1945 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Bethlehem Steel Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) James Reda Mary Starta 19a. Informant's Name/Relationship (Type, Print) SON 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1524 National Road, Baltimore, Maryland 21237 James Reda 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremetlon 3 ☐ Removal from State Sacred Heart of Jesus 1/26/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr., Funeral Hm. 21. Signature of Funerel Service Licensee 263 S. Conkling St., Baltimore, Maryland 21224 Du er the disease, or comblications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, bean failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gastrointestinal Hemorrhage disease or conditi resulting in deeth) Due to (or as a consequence of): Bradycardia Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of): Arteriosclerotic Coronary Artery Disease that initiated events Due to (or as a consequence of): resulting in death) Last Chronic Obstructive Pulmonary Disease Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? S/Pendovascular Abdominal Anuerysm Repair 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nuknown Coagulopathy 24b. Were autopsy findings 24a. Was en autopsy performed? available prior to completion of cause of deeth? Retroperitoneal Hematoma 1 ☐ Yes 2 No 1 Yes 2 No 25. Was cese referred to medical 26. Plece of Death (Check only one) 1 Yes 2 No Hospitel: 1₺ Inpatient 2☐ ER/Outpetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1% Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29b. Signeture and title of contifier 29c. License number

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Examiner

Funeral

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The law requires that the death certificete be executed

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P.O.

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Physician/Medical

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Certification: To

Medical

21215-0020

Baltimore, Maryland

31. Dete filed (Month, Dey, Year) JAN 2 6 1999

30. Name and address of person who completed

Calvin E. Jones M.D. 4940 Eastern Ave. Baltimore, Maryland 21224 32. Registrar's Signeture

of death (Item 23e) (Type, Print)

D06251

1 10 - 2 - 4 Arrest Transfer Notes to the first term and Alfred Miller Co. 1982

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3:15 AM **Physician** Keynolds allie January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** BonSecour Hospital NA Baltimore 7. Age (In yrs. last birthday) 92 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-28-06 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 20XF Months Days Hours Min 214-58-6591 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Yas 2□ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 1814 East 29th Street Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Ricen, etc.) 14. Bace - Amarican Indian Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Black by 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) 5th Grade College (1-4or 5+) NA Disabled unemployed 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Fether's Name (First, Middle, Last) Tom Rowe Indianna Bullock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 1814 E. 29th Street Rebecca Alston other 20b. Place of Disposition (Nama of cametery, crematory or other place)
Baltimore Cemetery 01-27-99 20c. Location - City or Town, State 20e. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21202 21. Signature of Funeral Sarvice Licensas 22. Name and Address of Facility WM.C.March FH 1101 E. North Avenue 23a. Part T. Enter the disaasa, or complications that caused the dean shock, or heart failure. List only one ceuse on each line. 62 Do not enter the moda of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner DSIS physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 88 950 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to been si 24a. Was an autopsy performed? Completed completion of cause of death? ata has b 1 ☐ Yes 2 ☐ No 2 PINO certificata Physician: To Be 25. Was cese referred to medical examiner? director, 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After this 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Natural 5 Pending investigation To the Hospital or Artername, within 24 hours after death.

To the Funeral Director; After the Funeral tilled in by the furor Attending 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated 29a. Cartifier edical 2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 2000 West Baltimore St. 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

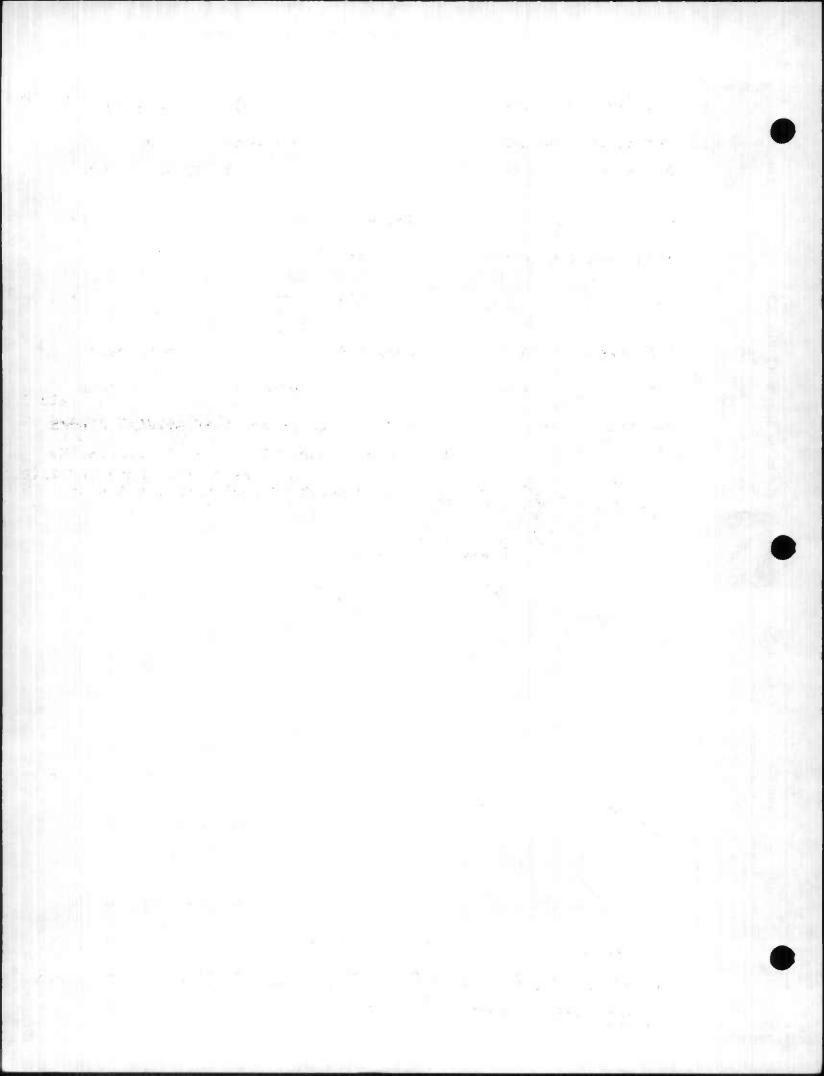
32. Registrar's Signature

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31. Date filed (Month, Day, Year)

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Item: 10e per F.H G-767 1/26/99 reb Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Earnest C. Roane January 20, 99 21:30pm /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2500 East Chase Street Baltimore Il Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 A 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys Hours XIXM 2DF 71 Yrs Director 222-16-9952 11-11-27 Usual Residenca of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Med cal Examinat must be notified at MD NA 1 Yes 2 No Baltimore Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 2500 E. Chase St. 1614 North Fulton Avenue 21213 USA permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health and Mental Hygiene. Important: It if team 27 is marked other than "natural", or items 23, any Injury or other traumatic event, it Funeral 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Name of the Name of Yes, Give Yeer or Detes: 1 Yes XXNo Specify. Specify: Black by 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Flementery/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Co Steel worker 12th Grade NA 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Clarence Roane Dorinda Roane 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Ernestine Roane-Spence 1614 N. Fulton Avenue Baltimore, Maryland 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, StateM D . 20a. Method of Disposition Burial 2 Cremation 3 Removel Irom State
4 Donation 5 Other (Specify) Garrison Forest VA Cem. 01-29-99 Owings Mills 21. Signature of Juneral Service Licenses 22. Name and Address of Fecility Baltimore, Maryland 21202 any le WM.C.March FH 1101 E. North Avenue 23a. Firt1. Enter the disease, or complications that caused the deeth. Approximate intervel Between Onset and Deeth Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? ed by the a signed by t 20 No 3 Probably 4 Unknown 1 Yes þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen page 2 s 1 ☐ Yes 2 No 1 Yes certificate Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28d. Describe how Injury occurred 27. Menner of Beeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a. Certifier (s) and manner es stated. 2 Madical Examinar: On the besis of examination end/or investigation, in my opinion, death occurred at the time, dete and plece, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 29b. Signature an

State Registrar 31. Date High Month, Day, 1999

Richard F.

32. Registrer's Signature

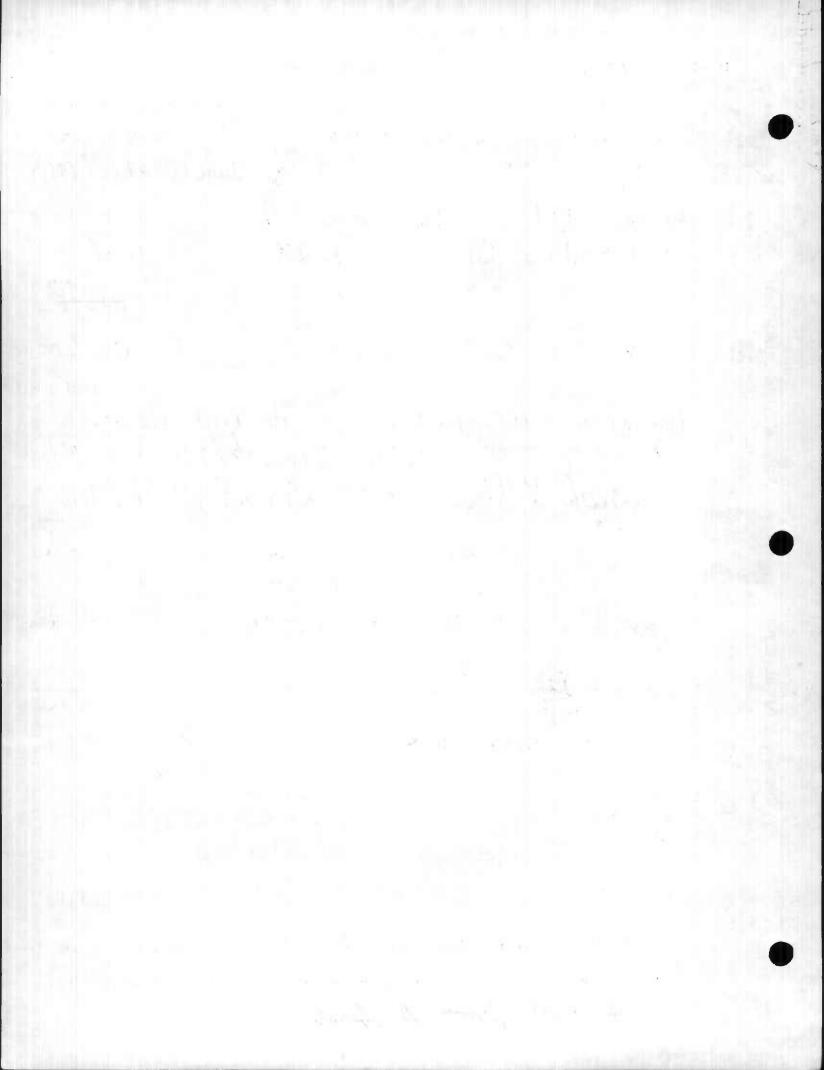
30. Name and address of purion who completed cause of death (Item 23a) (Type, Print)

Sparks

Tyson M.D. 936 West North Ave. Balt. Md. 21217

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Item#14 per FH G767 1/26/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** CATHERINE ROSS 3:20 PM 1999 JA NUARY 20 /Medicai 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPITAL, BALTIMIKE BALTIMORE COLY SAMARITAN MD GOOD If Under 1 Year Months Deys If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, **Funeral** Deys 10M 2XF 266184770 June 86 Director Usuel Residence of Decedent with the Merylend 10e. Stete 10b. County 10c. City, Town or Locetion 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumstic event, the Modical Examinar must be notified at 1 Yes 2 No Director Maryland more 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 9 Funeral didd death 12. Wes Decadent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status pemit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or fee any Injury or other traumatic event, the Medical Example 2015. White 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify. Specify: P 3 Widowed 4 Divorced DIC Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working
life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be inknown 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ba Belai Mariner 16 verlea 0 61 20b. Place of Disposition (Name of cemptery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion Mem. Gardens 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility
Joseph L. Kus
2222 W. North 21. Signa re of Funeral Service License eral SALE. Balto, Md. 21216 cations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, to cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) RENAL 4 days PAILURE Examiner Physician/Medical Examiner AUPIRATION The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Last ENCOPHAWPATHY Division of Vital Records, P.O. Box 68760, HYPOXIC Due to (or es e consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ed by the deteched signed by t 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA py 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? should I Completed 24a. Wes en eutopsy INTRAVASCULAR COAGULPAT DISSEMINATED page 2 s r this certificete h 1 ☐ Yes 2 No 1 □ Yes 2 □ No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To After this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident neral Director: A 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) after 4 Homicide within 24 hours a To the Funeral D edicai 29a. Certifier Certifying Phyalclan: To the best of my knowledge, death occurred et the time, date end pleca, end due to the cause(s) end menner es stated. 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier 0-12556 JANUARY 20, 1999 CHAWLA, MD 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) SAMBRITON MOCPITAL, PACTIMORY MD AJAY CHAWLD, MD GOOD

State Registrar 31. Dete filed (Month, Dey, Year) JAN 2 6 1999 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Zelma Margaret Rullman January 16, 1999 11:45 pm /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Undar 24 Hrs. 7. Aga (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** Months Hours 10 M 20 F Vre 217-01-8312 95 Director Virginia Feb. 24 1903 Usual Rasidanca of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits "natural", or thems 23s or 28s-f show 1 Yas 2 No Cockeysville MD Baltimore Director 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? 300 International Circle 21030 USA Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedant Evar in U,S Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Nevar Married 2 Married 1 Yas 2 No 1 ☐ Yas 2 ☐ No Specify. Specify: White py 3 XWidowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Machine Operator Clothing n/a 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be permit. Pages 1 and 2 should be Department of Health and Mental I Important of New 27 is marked oil any Injury or other Mary Eleanor Via Luther Thomas Burke 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 300 International Circle, Cockeysville, MD 21030 MD Masonic Home/P.R. Baltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Balto. Wash. Crematory 1/19/99 Laurel, MD 21. Signature of Empiral Service Licen 22. Nama and Addrass of Facility Lemmon Funeral Home Lemmon owell M 10 W. Padonia Rd., Timonium, MD 21093 The state of the s Approximeta Interval Batween Onsat and Daath **Physician** /Medical Immediata Causa (Final Oncumonia Iweek disaesa or conditio resulting in deeth) Examiner Due to (or es e consequence ot): Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaase or injury that initiated events rasulting in death) Last and burial-trar Dua to (or as a consequence ot): be exec P.O. Box 68760, physician Physician/Medical the Dua to (or as a consequence of) 80 attending | 23b. Did tobacco use contribute to the cause of death? Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yee 2 (No 3 Probably 4 Unknown signed l Division of Vital Records, by 24b. Were eutopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen : page 2 2 No 1 Yas 2 No certificate or Attending Physician: after death. Director: After this certific director, 25. Was casa rafarred to medical Be 26. Placa of Deeth (Check only one) axaminar? 1 ☐ Yas 2 🕱 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 5 Pending invastigation 1 Neturat 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 3 4 Homicida To the Hospital within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated. Medical 29a, Certifia 29c. Licansa number 29d, Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar Brune MD D40208

State Registrar

DHMH 16 Rev 6/95

York Rd

1205

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32. Regis ar's Signatura

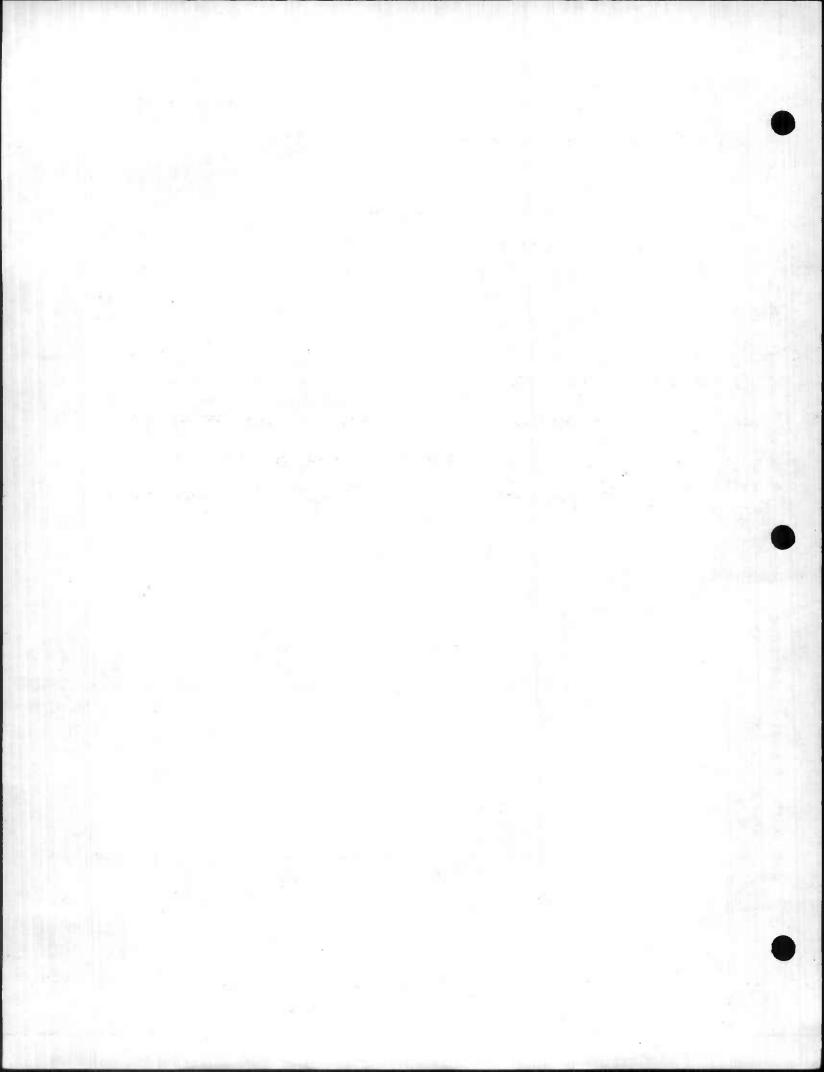
Ste 32c Lutherville Md 21093

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

Breiner MD

JAN 26 1999

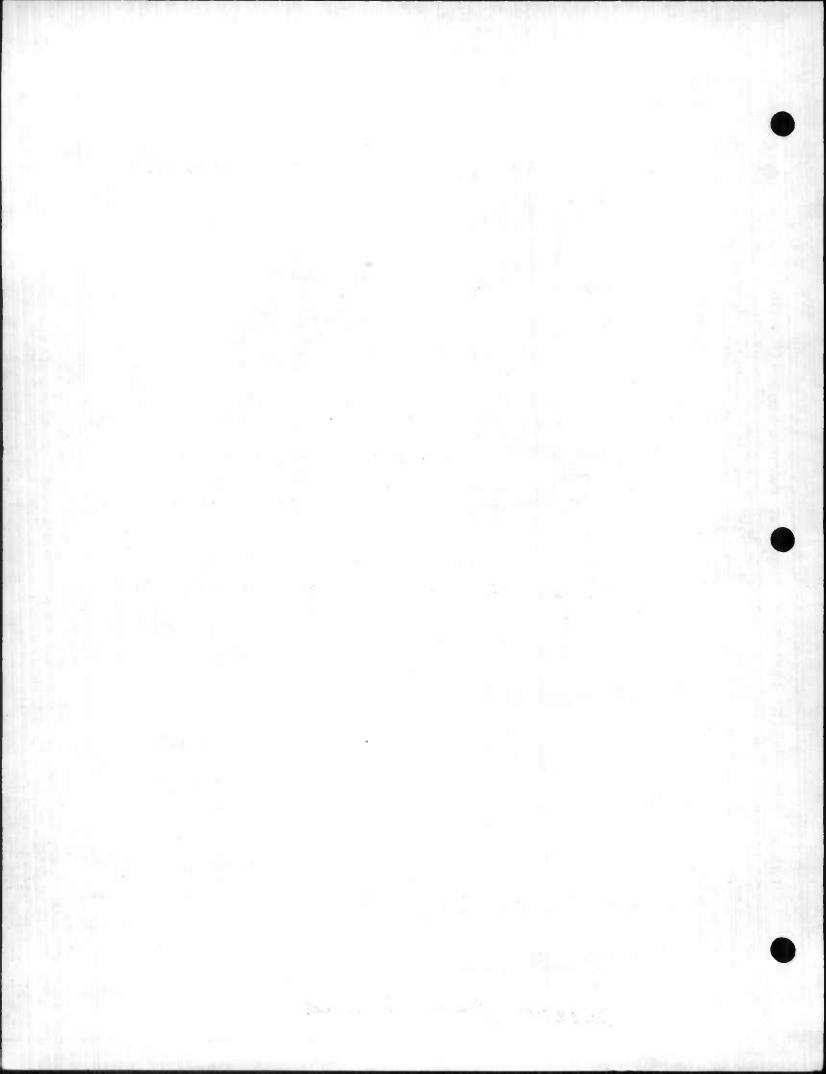
31. Data filed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene 99 0 1 7 8 L

				Certifica	ate of D	eath		Reg. No.		
		1. Decedent's Nama (First, Middle, Last)					2. Data of De Month	ath Dev	Year	3. Tima of Death
8	Physician /Medical	MARGARE	T C.	REY	NOL	DS.	JAN		999	4:00PM
	Examiner	4a Facility Nama (If not institution, give stre	et and number)		4b	. City, Town, or Lo		4c. County	of Death	
	Funeral	UNIVERSITY OF MA 5. Social Security Number 6. Sex	RYLAND 7. Age (In yrs. I	last birthday) If Uni	der 1 Year	BALTIMD If Under 24 Hrs.		N/A	9 Rirthol	lace (State or Foreign
	Director	173-38-6529 1 M	2KF 51	Yrs. Month	ns Days	Hours Min.	8. Data of Bir (Month, De 11/27	/1947	PENN	SYLVANIA
fland	B w	10a. Stata 10b. County	10c. City	y, Town or Location					10	Od. Inside City Limits
Na Man	or 28a-f sh be notified a	PA LANCASTER	EL	IZABETHT						1 ☐ Yes 2 ☑ No
th with th		10e. Street and Number 3356 TURNPIKE RI).	10f.	Zip Code 17022	2		10g. Citizen of V USA	Vhet Count	iry?
5-0020 72 hours after dea	Examiner must by Funeral	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U, Armed Forces? 1 ∐ Yas 2 2 No If Yas, Giva Year or Dates:	If Yas, s	cedent of His pecify Cuban 2010 No	panic Origin? (Sp , Mexican, Puarto Specify:	ecify Yes or No Rican, etc.)		e - America k, White, a	atc.
25-0	or the Medical to the Medical Completed	15. Decedent's Education (Specify only highest grade co	on mpleted)	16a. Decedent's U	suel Occupat	ion pring most of work	ina	16b. Kind of Bu	sinass/Ind	ustry
121 gar	Man alon	Elementary/Secondary (0-12)	College (1-4or 5+)	- 1010		ring most of work				
2 2	Co th	54		SCHOOL					CATI	ON
Maryland 21215-0020		17. Fathar's Name (First, Middle, Last) HAROLD CLARK				ANNA B	. ,	, maiden Sumam	Θ)	
ary	M Duran	19a. Informant's Name/Relationship (Type,	Print)	19b. Meiling Addre	ess (Street ar	nd Number or Run	al Route Numb	er, City or Town,	State, Zip	Code)
M, Ma	att a	LORIN A. REYNOLDS	(HUSB.)	3356 TU	RNPIK	E RD.	ELIZAE	ETHTOW	N, PA	. 17022.
ore sa te	756	20a. Method of Disposition	~	tace of Disposition (f	vame of or other place,		Data	20c. Location -	City or To	wn, Stata
Pages	ment ant: If ury o	1 ☐ Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Donation 5 ☐ Other (Specify)	MI MI	DDLETOWN	CEME	TERYO1	/28/99	MIDDL	ETOW	N, PA.
Baltimore	Depart import any inj ence.	21. Signature of Funaral Sarvice Licensee	711	HENR	and Address	JENKINS	& SO	NS CO.	212	
		23a. Part1. Entar tha disease, or complicati shock, or haart failura. List only ona c	ons thet caused the death			RD. BA			512.	Approximate
Ph	nysician	SHOCK, OF Haart failura. List only ona c	ausa on aacri iina.						1	Intarval Batween Onsat and Death
	Medical	Immediate Causa (Final disaasa or condition	PULMONA	RT H.	JOFR	TENS	100			POSTHS
E	kaminer	resulting in death) a		r as a consequence of	-	1210	10.			7401Hy
P	= 5		PRIMAR	y PUI	MUNI	9127 h	MYPER	TENSI	DN;	1.00 x1H
acute	sician and burial-transit	Sequentially list conditions, if any, laading to immediata cause. Entar Underlying		r as e consequence o	of):					
, s	clan clan purial	1 Cause (Disease or Injury								
: 68760, rtificate be executed	physician as the buria	that initiated events rasulting in death) Last	Due to (or	as a consequence of	n):					
	ding p	d								
death cer	d by the attendinetached for usa									
F.C.	signed by the a lid be detached f	Part II. Other significant conditions contribu	uting to death but not rasu	ulting in the underlyin	g causa giver	n in Part i.				the cause of death?
	gned be dete						10	108 2LINO	3 F100	oably 4 10 Unknown
cords, P.O	shou		1.176	•		BE-		an autopsy ormed?	ava	era autopsy findings milable prior to mpletion of cause
I Rec	page 2	Life and the second					10	Yas 200No		death? ∃Yas 2□ No
<u>a</u>	certificate rector, pag Be Co	25. Was casa referred to medical				OC Diseased Dead			11] 785 ZLI NO
Of VIta Physician:		examinar?	ital: ↑⊠Inpatient 2□	ER/Outpatient 3	DOA Other	26. Place of Deat		dence 6 □Oth	er /Sneciń	
ng Phy	eath. or: After this c the funeral dir cation: To		8a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury	at		how injury occur		7
2 5	irect in by	2 Accident invastigation 3 Suicide 6 Could not be determined	8a. Place of Injury - At ho building, etc. (Specify	ma, farm, street, fact		as 2 No	28f. Location (City or To	Street and Numb wn, Stete)	er or Rura	I Route Number,
Hospital	within 24 hours after d To the Funeral Direct completely filled in by Medical Certifi		n: To the best of my know On the basis of axaminat							
To the	ithin 2 the comple	29b. Signatura and titla of certifier	end manner steted.		29c. License	nu <i>m</i> ber		29d. Data signe	d (Month, I	Day, Year)
F	≱ ⊢ 8	1 112 1/10 1		4 3 1 9	0	201		To.	2 3	1000
		30. Nema and address of person who compl	alad cause of death /h	23a) (Tuna Drint)	F 10	206		Jan.	73	, 1997
)		ATTAN KAS	ID, mod	. 22	South	GREEN	EST.	EALD.	m	21210
	State Registrar	31. Data filed (Month, Day, Year) JAN 2 2 199	32. Registrar's Signal	tura \mathcal{G} .	Sport	number 206 CREEN		/		



that the death certificate be axecu P.O. Box 68760. Division of Vital Records, Hospital or Attending Physician:

with the Maryland

death \

Baltimore, Maryland 21215-0020

State Registrar

-11 31. Dete filed (Month, Day, Year)

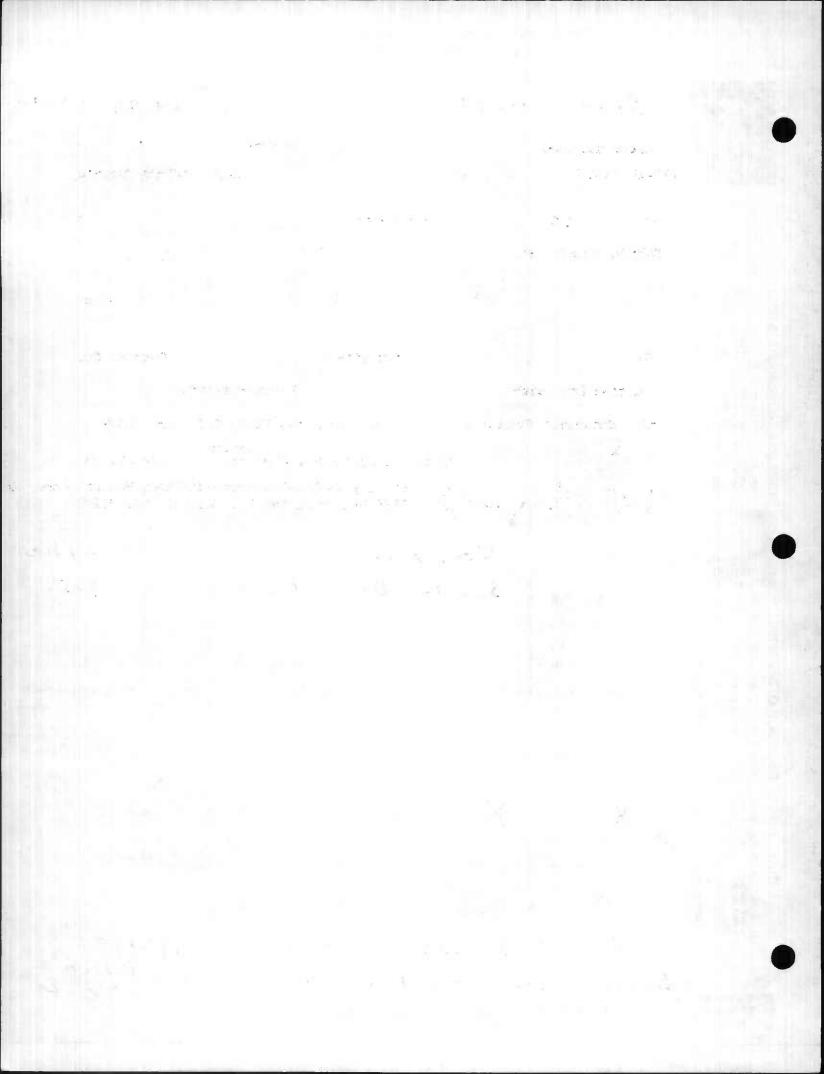
JAN 26 1999

30. Name end eddress of person who completed ceuse of deem (Item 23e) (Type, Print)

3 200 32. Registrar's Signeture

Plac Site 815 B. 1to md St. P. 1 0/

DHMH 16 Ray 6/95



Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month Day **Physician** Rosenberger Leo 9:17 PM JAN 1999 22 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner St. Elizabeth Nursing and Rehab. Center N/A Baltimore 7. Aga (In yrs. last birthday) If Under 1 Year Months Days 6. Sax 1X M 2□ F 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** Hours Min Yrs. Director 212-01-6893 88 APR. 11, 1910 Maryland Usual Residence of Dacedant 10a Stata 10b. Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or ferms 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas No Director Catonsville Maryland Baltimore the 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21228 20 Briar Wood Road USA Funerai 12. Was Decedant Evar In U,S. Armed Forcas? 1 [XYas 2 □ No WW I I If Yes, Giva Yaar or Datas: 14. Race - American Indian, Black, White, etc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) permit. Peges 1 end 2 should be filed within 72 hours after Depertment of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturelt, or the any injury or other traumatic event, the Mentel Exercise. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: White þ 3 Widowad 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Shipping Elementery/Secondary (0-12) College (1-4or 5+) Company Office Manager 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Be John Rosenberger Annie Schwindel 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Baltimore, MD 21218 1513 Tunlaw Road Fr. John Delclos/nephew 20b. Place of Disposition (Name of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1 A Burlai 2 Cramation 3 Ramoval from Stata Woodlawn Cemetery 1/25/99 Baltimore, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
MacNabb Funeral Home, 21. Signatura of Fundral Sarvice Licenses MacNabb Funeral Home, P.

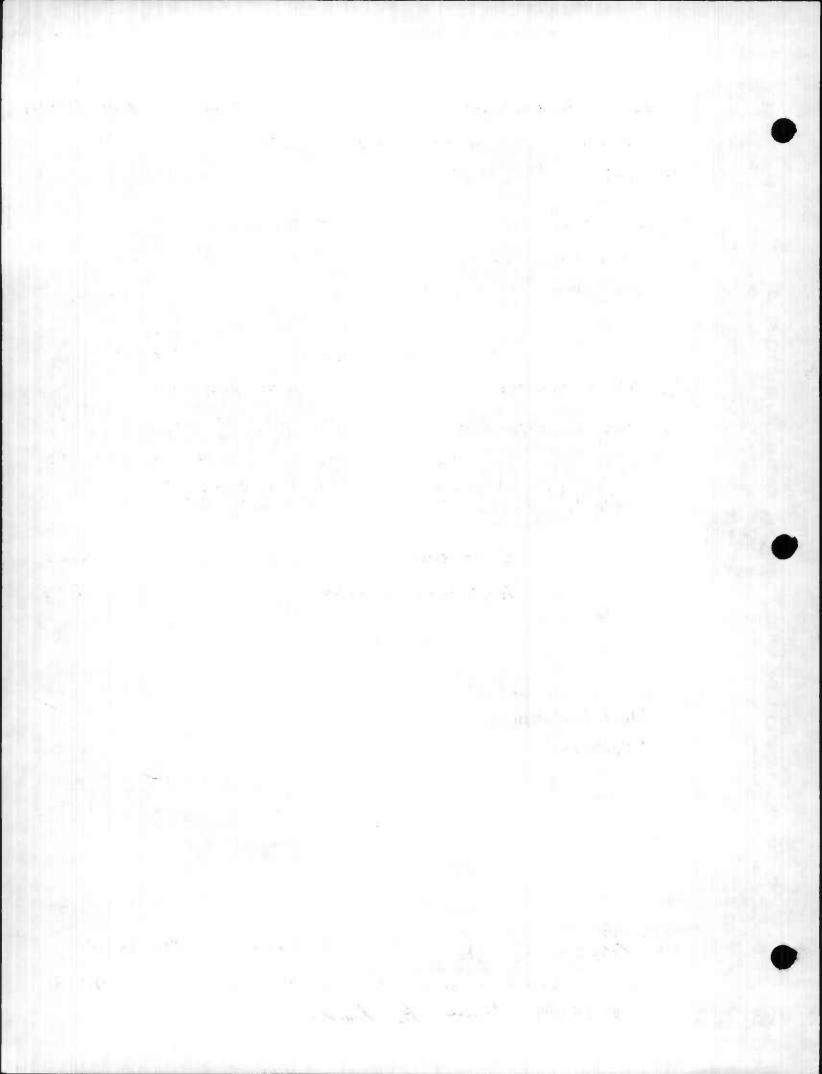
Drwn F. McDonald

301 Frederick Road Balt

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21228 Approximata interval Batween Onsat and Death **Physician** /Medical Immediate Causa (Final Colon cancet disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of): Examiner Orsease Years A12 heimers physician end s the burial-trans Sequentially list conditions, if any, leeding to immadiata causa. Enter Underlying Causa (Disease or Injury that initieled events resulting in death) Last Dua to (or as a consaquance of): Records, P.O. Box 68760. Physician/Medical Dua to (or es e consequance of) 80 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t 3 Probably 4 Onknown 1 Yes 2 No Atrial Fibrillation 2 24b. Ware eutopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 Yas 2 TNO 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Chack only one) Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 10 28a. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 27. Mannar of Death 28h Time of Certification: 28c. Injury at Work? 1 Matural 5 Panding 1 Tas 2 No death. Invastigation efter death Director: / 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, ferm, straat, factory, offica building, atc. (Specify) 4 | Homicide 24 hours 29a. Cartifiar 1号 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) end mennar as stated. To the Hosp within 24 hor To the Fune completely fi Medicai 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, deta and place, and due to the causa(s) and manner stated. (Check only one) 29b. Signature and this of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa number 05-2544 JAN 23. 30. Name and address of person who completed cause of death (Itam 23e) (Type, Print) Benjamin S. Lee, H.D. Rolling Rd # 4 Catousville UD 500 N.

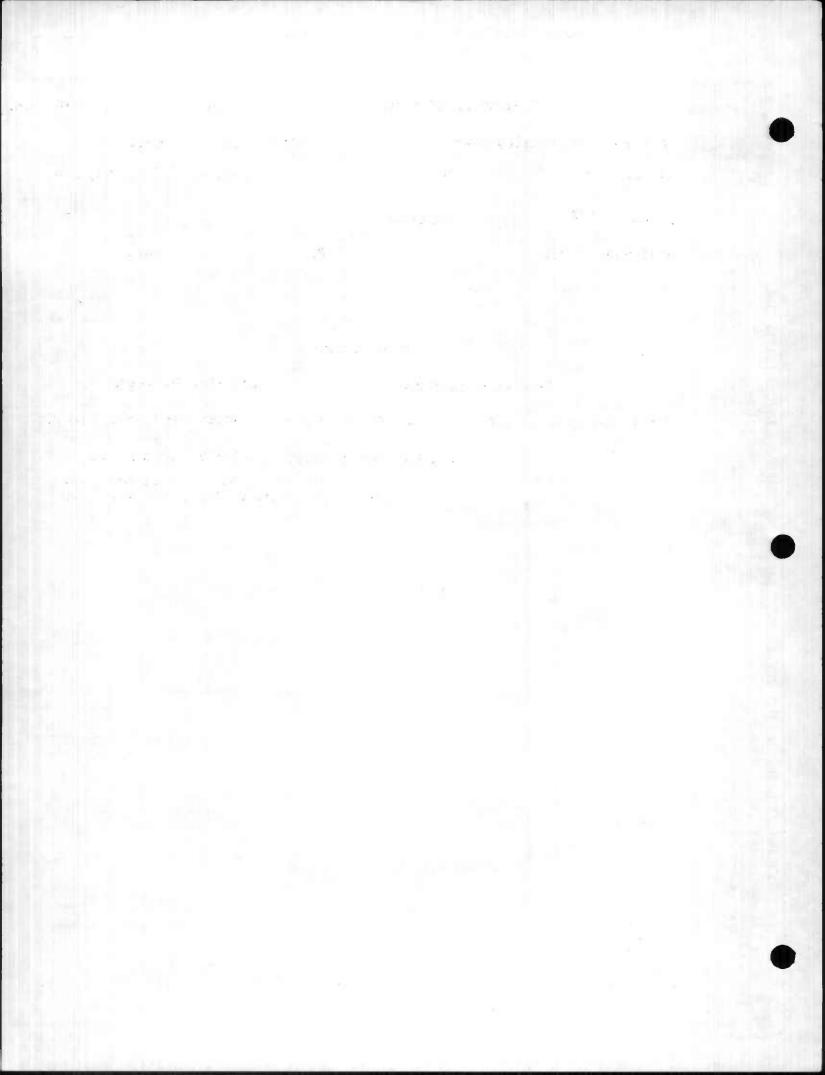
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32. Begistrar's Signatura



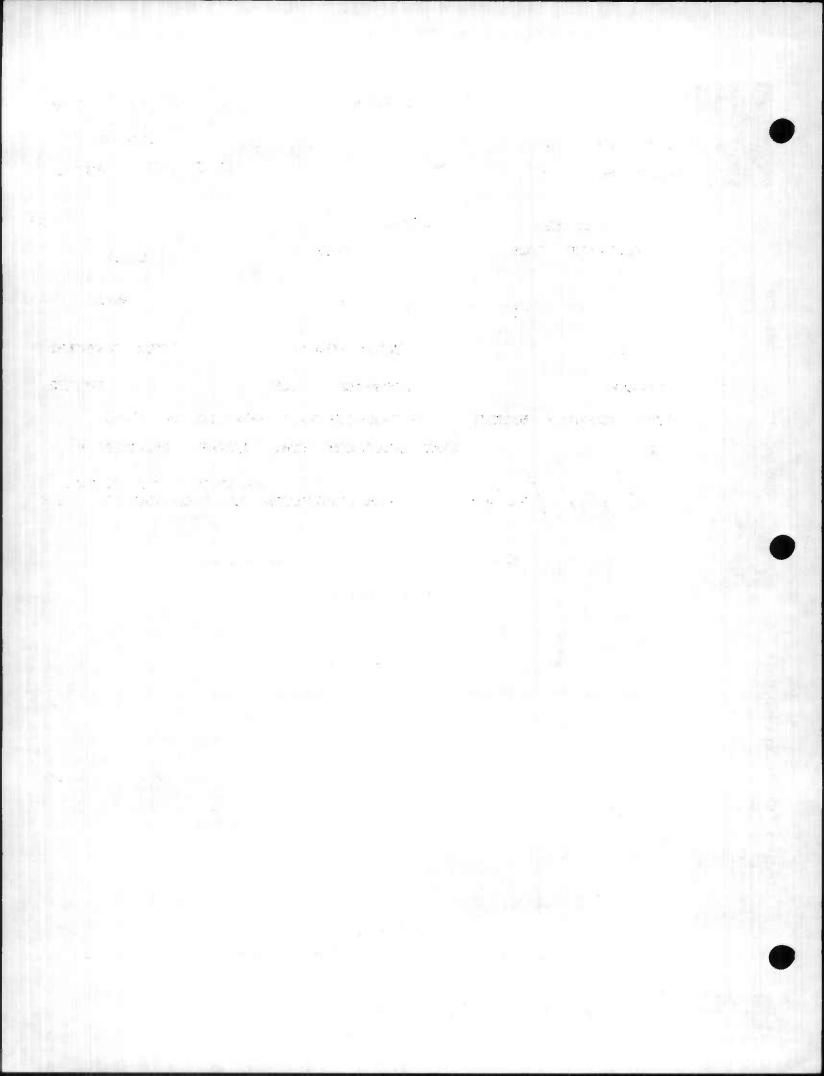
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			270	Ce	rtifica	te of I	Death		Reg. No.			
	1. Decedent's Name (First, Middle, L	.ast)						2. Date of Dea	ıth	Voor	3. Time of Deeth	
Physician /Medical		Raymon	d E. Ro	obinsor	1			Januar	y 24	1999	12:05 P.M	
Examiner	4a Facility Name (If not Institution, g	ive street end nur	nber)			4	b. City, Town, o	or Location of Death	4c. Coun	ty of Death		
	Forrest Haven 1	Nursing :	Home				Catons		Ba1	timore	2	
Funeral Director	5. Social Security Number 6. 215 03 1319	Sex 120 M 2□ F	7. Age (In yrs. 7 5	last birthday) Yrs.	Months	Days	If Under 24 H Hours Mi		1923		place (State or Foreign ntry) ryland	
show sd.at	Usual Residence of Decedent 10a. State 10b. County Mary 1 and N/A			ity, Town or Lo						1	0d. Inside City Limits	
cto	Maryland N/A		Ba	altimor	e						1∭ Yes 2□ No	
23e or 28e-1 s. int be notified al Director	10e. Street and Number 1819 Hope Stree	t			10f. Z	ip Code 2120	2		10g. Citizen o		itry?	
si", or items 23e or 28e4 shores must be notified at Exeminar must be notified at by Funeral Director	11. Marital Status 1⊠ Never Married 2□ Married 3□ Widowed 4□ Divorced	Armed Fo	2X No	J,S. 13.	Was Dec If Yes, sp 1 Yes		ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Re BI	ace - Americ lack, White, hity: Wh		
"natural",	15. Decedent's	Education		16a. Dece	dent's Us	uel Occup	ation during most of w	working	16b. Kind of	Business/Ind	dustry	
marked other than "natura imatic event, the Medical I To Be Completed	(Specify only highest g	College (1	-4or 5+)			orkec	_	VOIKING	ľ	N/A		
a othe	17. Father's Name (First, Middle, Las	st)					18. Mother's N	lame (First, Middle,	Meiden Sume	eme)	F (1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	
To B		Carroll	E. Rob	inson				Mary Etta	Shoem	aker		
10 E	19a. Informant's Name/Relationship Hattie Robinson		ter		-	ss (Street		Rural Route Number			code) land 21122	
important: If frem 27 eny injury or other ti once.	20a. Method of Disposition 1 Buriai 2 Cremation 3 4 Donation 5 Other (Spec		State	Place of Dispercemetery, cre	metory or	other plea		Date 1/26/99	20c. Location		own, State aryland	
for use as the buriel-transit and long state as the buriel-transit and long state are clan/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	e b c	Due to (or as a conse	quence of):	Neur	noria				
of for use	Part II. Other classificant annuisiana	a a stallbution to de							23b. Did tobacco usa contribute to the cause of death			
be detached for use a by Physician/M	Par II. Other significant conditions	contributing to de							Yes 2□No 3□Probably 4☑Unknow			
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page Com		1 □ Yes 2 □ No								1[☐ Yes 2 1 No	
certificata rector, pag	25. Wes case referred to medical examiner?	Hoepital				Oth		Deeth (Check only o	ne)			
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Pletely file		aminar: On the ba	asis of examina					ace, and due to the courred at the time,				
To the Funeral completely filled Medical C	29b. Signature and title of certifier	and meni	ner stated.		2	9c. Licens	e number		29d. Dalle sig	ned (Month	Day Year)	
2 8 _	Jasueu	Vale	ran			02	8195		1/25	199		
	30 Name and address of person who	completed caus	e of death (Ite		Print)	the	COHTS +	HE BE	le To.	M	20208	
State	31. Date filed (Month, Day, Year)	32. R	egistrer's Sign	eture L	1		,					



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JACK ROSENBAIM JACK ROSENBAIM JACK ROSENBAIM JACK ROSENBAIM As Facility Name (if not institution, gave street end number) 21 GREENWICH PLACE Social Security William RATTIVORS BALTITIONS JACK MD 20 T 7 Apr (in pic aur chindry) William and control to the control of the control		1. Decedanta Na	ma (First, Middla,	Last)			rtificate c			ata of Death			3. Tima of Death
Copy Town, or Location of Orest Ac. Copy Town or Location Ac. Copy Town Ac		JACK				ROSENI	BAUM				20 ^{Day} 1999	Yaar)	7 PM
Control of Part Control of					ber)					of Deeth			
100 State 100 Control 100 Chry 100 C		5. Social Sacurity	Number	6. Sax 7				er If Undar 24		ata of Birth			lace (Stata or Foreign try) OLAND
10. Sirved another bland and the part of t		Usuel Residence	of Decedent		10c. City	, Town or Lo	ocation					10	Od. Insida City Limits
21 CREENWICH PLACE 12 Water Descent Form I U.S. 13 Wee Descent Form I U.S. 13 Wee Descent Form I U.S. 14 Ween Descent Form I U.S. 15 Descent Form I U.S. 16 Ween Market Control (Specify Vas of North Market Control (Specify Vas of Nor	tor	MD	ВАГ.ТТМ	ORE	BA	LTIMOR	RE						1□ Yas 2□No
ACTIVITIES The Control of Contro			lumber				,			10			try?
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15ALUNE 19a. Informant's NameRelationship (Type, Print) 21 GREENWICH PLACE BALTIMORE MD. 21208 220. Method of Disposition 1 Mounts 2 Coramation 3 Gamoval from State 3 Corama	ဝိ			ast)					Nama (Firs	t, Middle, A			110222
SIMMY SCHMIDT DAUGHTER 20. Method of Disposition 1 Separate 2 Command of State 4 Docation 5 Command of Disposition 1 Separate 5 Command of Disposition 21. Signatures of Lucinetal Services Lucinetal 22. Signatures of Lucinetal Services Lucinetal 23. Signatures of Lucinetal Services Lucinetal 24. Signatures of Lucinetal Services Lucinetal 25. Signatures of Lucinetal Services Lucinetal 26. Separate of Lucinetal Services Lucinetal 27. Signatures of Lucinetal Services Lucinetal 28. Signatures of Lucinetal Services Lucinetal 28. Signatures of Lucinetal Services Lucinetal 29. Signatures of Lucinetal Services Lucinetal 29. Signatures of Lucinetal Services Lucinetal 20. Lucinetal Services Lucinetal S	ToB	ISADOR	Œ			ROS	ENBAUM	LENA				S.	TEINER
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27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 5 Panding Invastigation 28a. Place of Injury At home, farm, streat, factory, office 26f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certiflar (Check only one) 1 Cartifying Physician: To the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29b. Signeture and title of cartifier 29c. Licanse number 29d. Data signed (Month, Dey, Year) 27. Manner of Death (Month, Day Year) 28b. Time of Injury at Work? 1 Yes 2 No 28d. Dascribe how Injury occurred 28d. Dascribe how Injury occ	pieted by Physician/Medical Examiner	disease or condit resulting in death Sequentially list of fany, leading to couse. Enter Uncause (Disease that Initiated ever resulting in death	conditions, immediate darlying or injury nts u) Last	a. Coy b. A t c. 4 A	Due to (or Dua to (or A - Lee	r as a conseq	quence of): 71 c / r c quence of): quence of):	Lor A	(-(·))	23b. Did to 1 U You	obacco use co es 2 No n autopsy mad?	3 Prot	o the cause of death? bebly Unknown are autopsy findings eliable prior to mplation of ceuse deeth?
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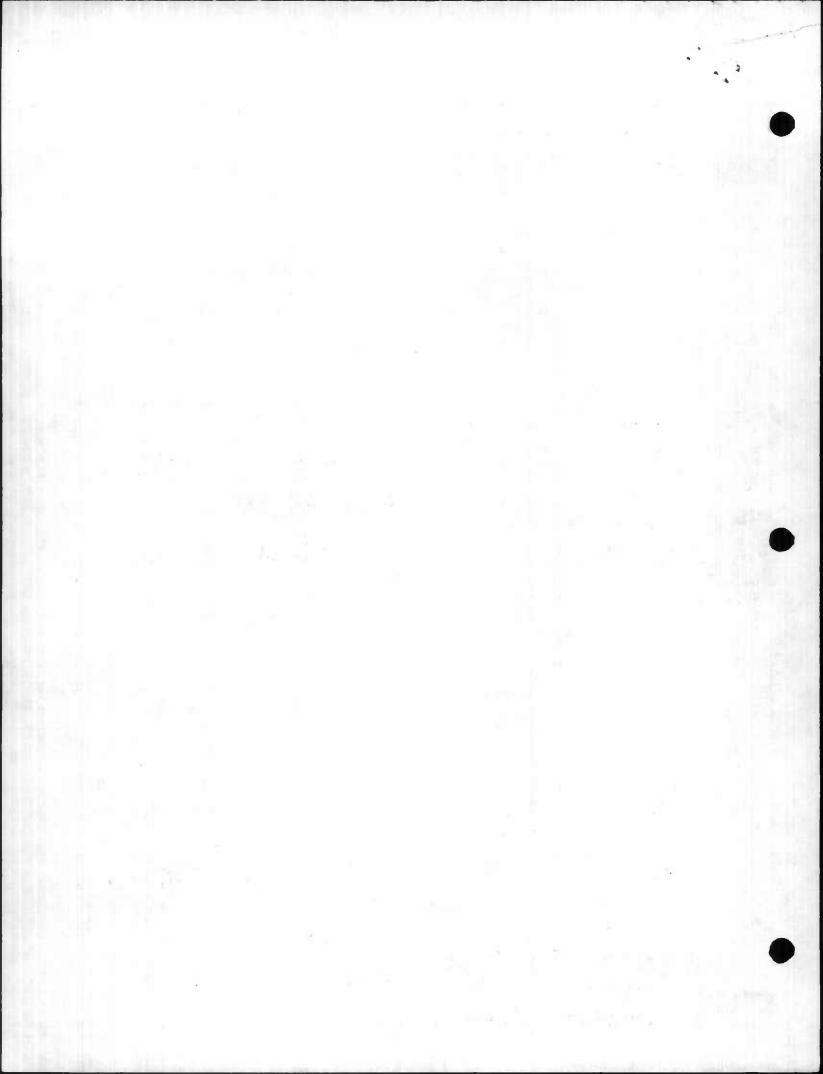


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 1 7 8 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Edwin . BRICE 1999 JANUARY 0130 AM 13, /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1800 NORTH MILTON AVENUE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days HOM 2□ F Months 219-80-1256 35 DEC- 30 Mar Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Solhmer 1 Nes 2 No Mary / Sys 10e. Street and Number 28a-f Directo 10f. Zip Code 10g. Citizen of What Country? 8 E'moro 21013 3833 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. Never Merried 2 Merried 8 Baltimore, Maryland 21215-0020 1 Yes 2 kNo Specify: à 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Private BUSINESS Hygiens. Ther than Elementery/Secondery (0-12) College (1-4or 5+) just GRade MECHANIC 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and 2 should be fill Health and Mental H Nem 27 is marked oth Edward L. SHUffers marian HARRIS 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1522 LAKESIDE AUG permit. Pages 1 and 2 Department of Health a Important: If Iban 27 is any Injury or other tra SHUFFERO tather Edward BALTIMOR, but 21218 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 18 Buriel 2 Cramation 3 Ramoval from Stata 1-20 WOOD COWN, Mary losp WOODLAUR ametery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Off A TIM An - SARRI'S ROBEL Home 21. Signature of Fuperal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaesa or condition resulting in death) Examiner Due to (or es e consequence of) Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of) Box 68760. Physician/Medicai Due to (or as a consequence of): 23h. Did tobacco use contribute to the cause of death? P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Ves 2 No 3 Probably 4 Unknown Records. g 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Ves 2□ No res 2□ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitei: Other: 4 Nursing Home 1 Xes 2 No Medical Certification: To 5 ☐ Residence 6 🖾 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this SCENE 27. Menner of Death 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funera 28c. Injury at Work? After Subj 5 Pending Invastigetion 1 Netural 1 Yes 2 No 20 2 Accident 3 Suicide 6 Could not be Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, p. City or Town, State) Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b, Signats 29c. License number JANUARY 13, 1999 O.C.M.E. 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

111 Penn S 111 Penn Street, Baltimore, Maryland 21201 -on 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State 2 6 1999 Registrar

DHMH 16 Ray 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 1 7 9 0

			Certificate	e of Death		Reg. No.	
	1. Decedent's Name (First, Middle, Las	1)			2. Date of I		3. Time of Death
Physician	VIRGINIA H. S	EAWELL			JANUA	Day 1RY 20, 1	Year 999 3:55 FM
/Medica Examine	4a Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of De		
	Saint Joseph I	Medical Cent	er	To	wson	В	altimore
Funeral	5. Social Security Number 6. S		last birthday) if Under Months	1 Year If Under Days Houra	24 Hrs. 8. Date of E	Birth Day, Year)	9. Birthplace (State or Foreign Country)
Director	[214-20-5544]	DM 21√F 88	Yrs.		7-16		YA VA
pu &	Usual Residence of Decedent 10a. State 10b. County	10c City	y, Town or Location				10d. Inside City Limits
show			, Town or Education	NA			1 □ Yes 2 No
the Market Protection	MD BALTIM	IURE	10f. Zip	1.4		10g. Citizen of W	hat Country?
A S S	100. Street and Number	D	101. 216	Clostil		Tog. Citizen of W	nat Country ?
5-0020 72 hours efter death with the Maryland naturel; or frems 23s or 28s-f show ace Examiner must be notified at	3101 WIN LAK	12. Was Decedent Ever In U.	C 13 Was Deced	ant of Hispanic Ori	gln? (Specify Yes or I	No. 14 Bace	- American Indian,
ter des	1 Never Married 2 Married	Armed Forces?	It Yes, spec	ify Cuban, Mexicar	, Puerto Rican, etc.)		white, etc.
D20 urs eff		It Yes, Give Year or Dates:	1 ☐ Yes 2	No Specify:		Specify:	BLACK
2 hou		ucation	16a. Decedent's Usue (Give kind of wor	l Occupation		16b. Kind of Bu	
1 21215-0 led within 72 ho lygiene. her than "naturn nt, me Madeel	(Specify only highest grades) Elementery/Secondary (0-12)	de completed) Coltege (1-4or 5+)	(Give kind of wor life. DO NOT us	k done during mos e retired)	t of working		
d within piene.	8 TH GRADE	2 YRS.	Nur	SE		HEALT	+ CARE
be filed tal Hygi d other event, I	17. Father's Name (First, Middle, Last)		Mark Mark	18. Mothe	er's Name (First, Midd	lle, Meiden Sumem	9)
larylan 2 should be and Mental is marked o	UNKNOWN			HENR	RIETTA RO	220	
Maryland 21215-0020 d 2 should be filed within 72 hours of his and Mental Hygiene. 7 is marked other than "natural; or traumatic event, the Madical Example TO Re Completed Hygiene.	19a. Intorment's Name/Reletionship (7	ype, Print)	19b. Mailing Address				
CENL	PEGGY BUSH DA	UGHTER	2300 EUTA		PT.9, BAI		
ges 1 en ti of Heal If item 2 or other	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		lace of Disposition (Nan emetery, crematory or of	ne of ther place)	Date	20c. Location -	City or Town, State
Peg Peg nent ant: b	4 Donation 5 Other (Specify	ARE	BUTUS CEME	TERY	1-26-99	BALTO.	MD
Baltimore, permit. Peges 1 er Department of Hee Important: If Item any injury or other and injury or other ance.	21. Signature of Funeral Service Licen	see	22. Name and	d Address of Facilii	ENE FUN	ERAI 6E	DUICE
m 89 E # 8	1) audon	(Groene)	VAUGHA	NITO NO	TU PIKE	BAITO. N	0.21229
	23a. Part 1. Enter the disease, or composhock, or heart tellure. List only	flications that caused the death	n. Do not enter the mode	e ot dying, such as	cardiac or respiratory	arrest,	Approximate Intervel Between
Physician	Silosi, Griday.	orio oddoo oir oddii iiro.					Onset and Death
/Medical	Immediate Cause (Final disease or condition	SEPTIC SHO	CK				
Examiner	resulting in death)	Due to (o	r es e consequence of):				
ovecuted inland inland		h					
60, be executed ician and burial-fransit	Sequentially list conditions,	Due to (o	r as a consequence of):				
		C					
certificate be an ording physician use as the buna	that initiated events resulting in death) Last	Due to (or	as a consequence of):				
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death ce estending of for use					1		
P.O. that the de by the deteched deteched	Part II. Other significant conditions co	entributing to death but not resu	ulting in the underlying or	ause given in Part I		1	tribute to the cause of death?
igned by be detected by Phy					1	Yes 2 70	3 Probably 4 Unknown
Vital Records, P.O. Box siden: The law requires that the death conflicte has been signed by the ettend frector, page 2 should be deteched for us. Be Commisted by Physician					24a. W	es en autopsy	24b. Were autopsy tindings
cord v require been signaled is should it					pe	rformed?	available prior to completion of cause of death?
The law ate hes b pege 2 s						1 × 2 × 2 × 2	
Vital Indicate certificate rector, pag				OS Diagram		Yes 2 No	1 Yes X No
Of Vita Physician: this certific ral director.		Hospitel: 1 Inpatient 2	ER/Outpatient 3□ DO	Othors	of Deeth (Check online of Deeth (Check online of Deeth (Check online of Deeth (Check online of		or (Snecify)
0 4 4 4		28a. Date of Injury	28b. Time of 2	8c. Injury at Work?		e how injury occurr	
ding F th. After funer	Natural 5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐	No		
Attending or death.	3 Suicide 6 Could not be determined	Zoe. Flace of injury - At no	ome, farm, street, factory	, office	28f. Location	(Street and Number	er or Rural Route Number,
Direction din	4 Homicide	building, etc. (Specify	1)		City or	Town, Stete)	
Division Complete Division of the Hospital or Attending P within 24 hours effer death. To the Funeral Director: Affect completely filled in by the funeral Medical Certification.	29a. Certifier Certifying Ph	valcian: To the best of my know					
Per Fu	(Check only 2 Medicat Examone)	iner: On the basis of examinat and manner stated.	tion and/or investigation,	in my opinion, dea	ith occurred at the tim	e, date and place, a	and due to the cause(s)
To the To the Comp			290	. License number		29d. Date signed	(Month, Day, Year)
,	1 Dans	no	tra D	30263		1-20	7-99
	30. Neme and eddress ot person who	completed cause of death (Item	23a) (Type, Print)	May 17 Fig.			
	FRANCIS T. KHOO		1 OSLER D	RIVE TO	WSON, MA	RYLAND 8	21204
State	31. Date tiled (Month, Day, Year)	32. Registrer Signa		Jan V	,		
* Registrar	IAN 27	3 1999 Dane	P.	popular			

LARRY		State of Maryla	and / Department of 2-22 Certificate	of Health and M	Mental Hygi	iene99	01791
Physician /Medical	LARRY DAV	ast)		or Death	2. Data of Death Month JANUARY	Day 20, 199	Year 9 2:56P.M.
Examiner	4a Facility Nama (If not institution, g KERNAN HOSPITAL			4b. City, Town, or L BALTIMOR	E	4c. County o	VA
Funeral Director	5. Social Security Number 6. 217–58–4663 Usual Rasidenca of Dacedent	Sex 7. Aga (/n y/	rs. last birthday) If Under 1 Y Months D	'aar If Under 24 Hrs. ays Hours Min.	8. Data of Birth (Month, Day, JUNE 5	1951	Birthplaca (State or Foreig Calabay) MARYLAND
h the Meryland r 28a-f show incomed a	10a. Stata 10b. County BALTIMO	RE 10c.	City, Town or Location RANDALLSTOWN				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
Uniter deeth with the Meine terms 23s or 28s4 entitles notified	10e, Street and Number 3703 CASSEN	ROAD	10f. Zip Co 211		10	U.S.A.	hat Country?
5-0020 72 hours after deeth with the Meryland natural; or items 23s or 28s4 show licel Examine must be notified at the dry Finners Director	3 ☐ Widowed 4 ♥ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva X Year or Data¥	U,S. 13. Was Decedent If Yas, specify 1 ☐ Yas 2 🎇	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	pecify Yas or No- Pican, etc.)	Black	- American Indian, c, Whita, etc. WHITE
2121 d within jiene. r than "	15. Decedent's (Specify only highast g Elamantery/Secondary (0-12)	Education rada complated) College (1-4or 5+)	16a. Decedent's Usuel O (Give kind of work d lifta. DO NOT use n PHOTOGRAPHER	ccupation lone during most of worl etired)	king	PHOTOG	
Maryland 2 d 2 should be filed the and Mental Hygi T le merked other treumetic event, I				18. Mother's Nam ROSALIE	na (First, Middle, M	laiden Sumams RUE	
Baltimore, permit. Peges 1 er Department of Has Important: If Item; any Injury or other once.	21. Signature of Puneral Service Lio 21. Signature of Puneral Service Lio 23a. Part1. Entar tha diseasa, or co shock, or heart failura. List on	In addle	8900 REI	ddress of Facility STERSTOWN	SOL LEVIN	SON & E	BROS. INC. MD 21208 Approximate Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	aDua to	NARCOTIC INTO	OXICATION			
60, be executed burial-transit		b. Due to	(or as a consequence of):				
0 20 0	thet initiated evants	Dua to	(or as a consequence of):				
P.O. hat the de dby the detached		contributing to death but not r	asulting in the underlying caus	e given in Part I.			tribute to the cause of death
ecords ew requires s been sign 2 should be					24a. Was ar perform		24b. Wera autopsy findings available prior to completion of cause of death?
Vital Relicion: The lacentificate he irector, page	25. Was case referred to medical			26. Place of Dea	th (Check only one		Yas 2 No
To this hy	27. Menner of Death 1 Netural 5 Pending	28a. Data of Injury (Month, Dey Year)		Other: 4 Nursing Hetnjury at Work?	oma 5 Resider		
Division of Attending P a ster death. I Director: After the funer of in by the funer Certification:	2 Accident invastigati 3 Suicida 6 Could not 4 Homicida determine	1 20 33	UNKNOWN M home, farm, street, factory, of city) KERNAN HOSPITAL	fice	UNKNOWN 28f. Location (Str. City or Town, BALTIMORE	. Steta) 2200	r or Rural Route Number, KERNAN BR.,

To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by

State

Medicai Cer

29a. Certifiar

32. Registrar's Signatura

and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

**Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

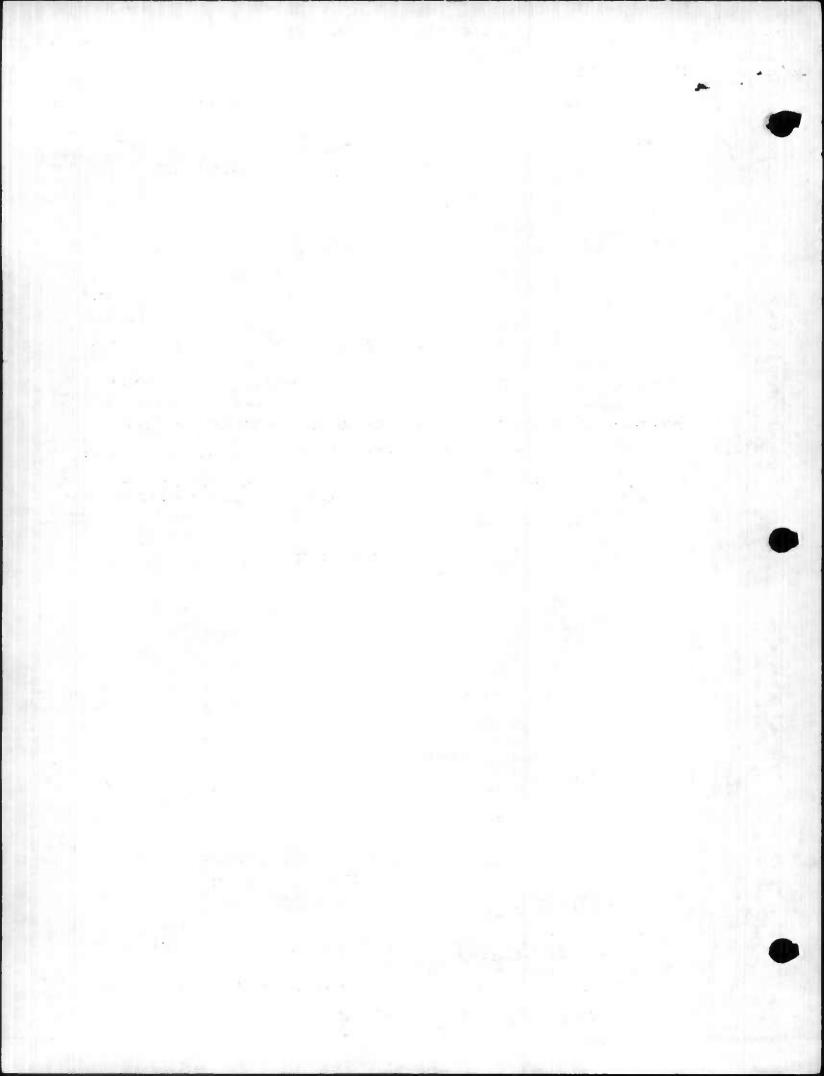
29c. License number O.C.M.E. BALTIMORE, MD.

29d. Date signed (Month, Day, Year)

JANUARY 21, 1999

JAN 26 1999

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Hygiene

Reg. No.

Martinu Louise Simms ITEMS: #23 PART I, 27 PER MEO G769 3-5-99 WR. Certificate of Death

0	I V	Mar	yland /	Department	01	Health	and	mental
3	Е	00	LID	0-466-4-	- 4	CD 41	_	

1. Decedeni's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARTINU LOUISE SIMMS 20. 1999 January 6:01 A.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1701 Cherry Hill Road Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days 1□ M 3□F 30 220-80-2188 Yrs. APR 6 1968 Director MD Usuel Residence of Decedeni 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits MD NA BALTIMORE Vas 2□ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 2502 TERRA FIRMA ROAD 21225 USA 'natural', or harns 23s Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? tv Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CHILDREN'S than Elementery/Secondary (0-12) College (1-4or 5+) 12th ASSISTANT MANAGER lyr CLOTHING STORE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) and Mental H Be is marked CLARENCE SIMMS JR. JOANN TURPIN 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . opartment of Health as important: if them 27 is any injury. JOANN SIMMS - MOTHER 7514 HAYSTACK DR. BALTO., MD 21244 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Siete Pages 1 1X Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY 12699 BALTIMORE, MARYLAND 21. Signet ure of Funeral Service Licansee MARCH FUNERAL HOME WEST, INC. 0 4300 WABASH AVE. BALTO., MD 21215 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA /Medical Examiner Due to (or as a consequence of): Examiner MYOCARDIAL FIBROSIS physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): 88 150 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t d be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed Deen 1 Nes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) at SCENE To 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 5 Pending Investigation Division Attending 1 Naturel s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide 6 To the Hospital o within 24 hours at To the Funeral D edical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifie 29c. License number O.C.M.E. January 20, 1999

State

Registrar

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1999

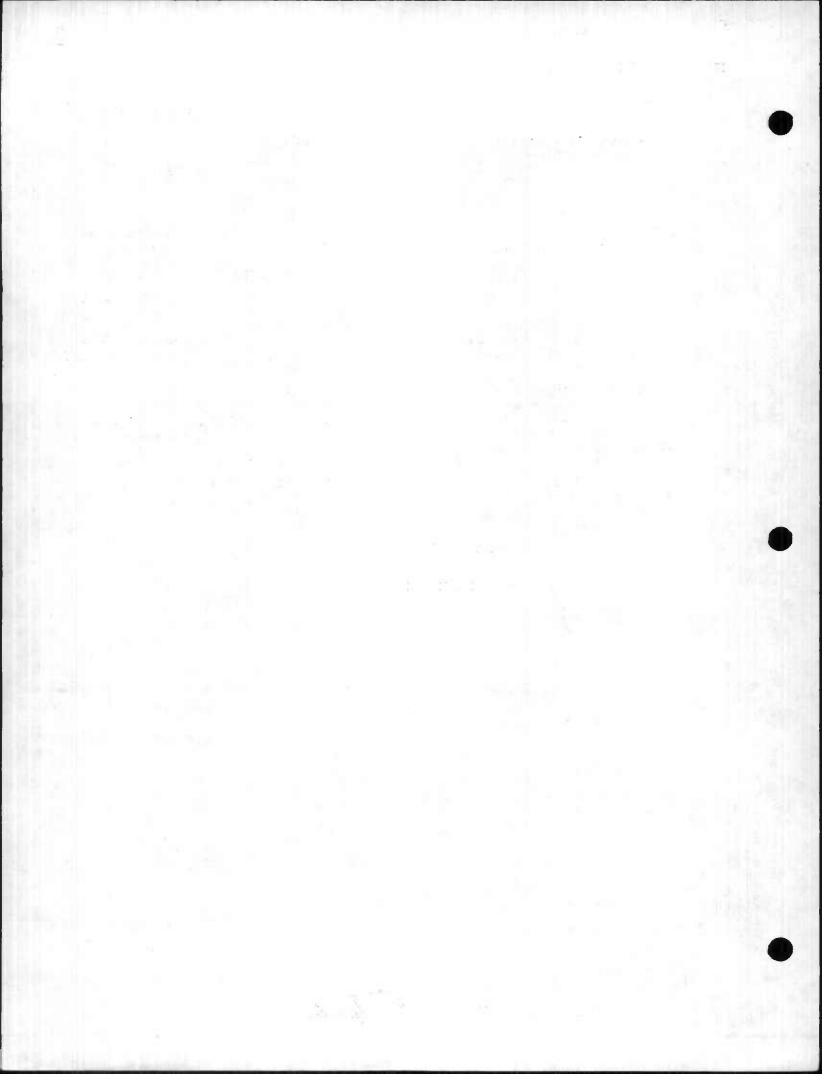
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31. Dete filed (Month, Day, Year)

JAN26

A. KORTE UN

32. Rebistrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month Year Cecilia Jeanette Scott 1999 4b. City, Town, or Location of Death 1:53 am 22 4a Facility Nema (If not institution, give street and number) 4c. County of Death Baltimore Franklin Sougre 7. Age (In yrs. last birthday) Koseda/e ter HOS If Under 1 Yaer 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 5. Sociel Security Number Months Deys Hours 1□M 25 F Yrs. 83 July 21,1915 Maryland 215-01-0019 Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Dundalk Maryland Baltimore 1 ☐ Yas 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21222 United States South Woodwell Road 205 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - Amarican Indian. Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yaer or Dates: 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Own Home Housewife 12 Years 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Catherine Virginia Long Thomas J. Brazier 19e. Informent's Neme/Reletionship (Type, Print) Daughter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Catherine C. Shoemaker 110 Patapsco Ave. Baltimore, Maryland 21222 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State Dete 1X Buriel 2 ☐ Cramation 3 ☐ Removel from Stete Sacred Ht. of Jesus Cem. 1/25/99 Dundalk, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Serv ce Lice 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland ming 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximete Intervel Between Onset end Deeth Immediete Ceuse (Finel neumonia diseese or condition resulting in deeth) Due to (or es a consequence of) estive Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting In death) Last Due to (or es e consequence of): Obstructive Chronis Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 2 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? 5 Pending invastigation 1 Neturel 1 Yes 2 No 2 ☐ Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

*2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at tha time, date end place, and due to the cause(s) and mannar statad. 29a. Certifier

Examiner Box 68760 Records, P.O. Division of Vital or Attending Hospital

altimore, Maryland

permit. Pages 1 and 2 should be Department of Health and Mental Important. If Nem 27 is marked or

Physician /Medical

physician

286

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The Funeral Director: After pletely filled in by the fun

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/Medical

Examiner

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Completed

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Certification: To

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"natural", or thems 23a or 26a-f show

must be.

To the Hosp within 24 hor To the Fune completely fi State

DHMH 16 Rev 6/95

Registrar

(Check only one)

29b. Signature and title of certifien

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 franklin 32. Registrer's Signature 00000

29c. License number

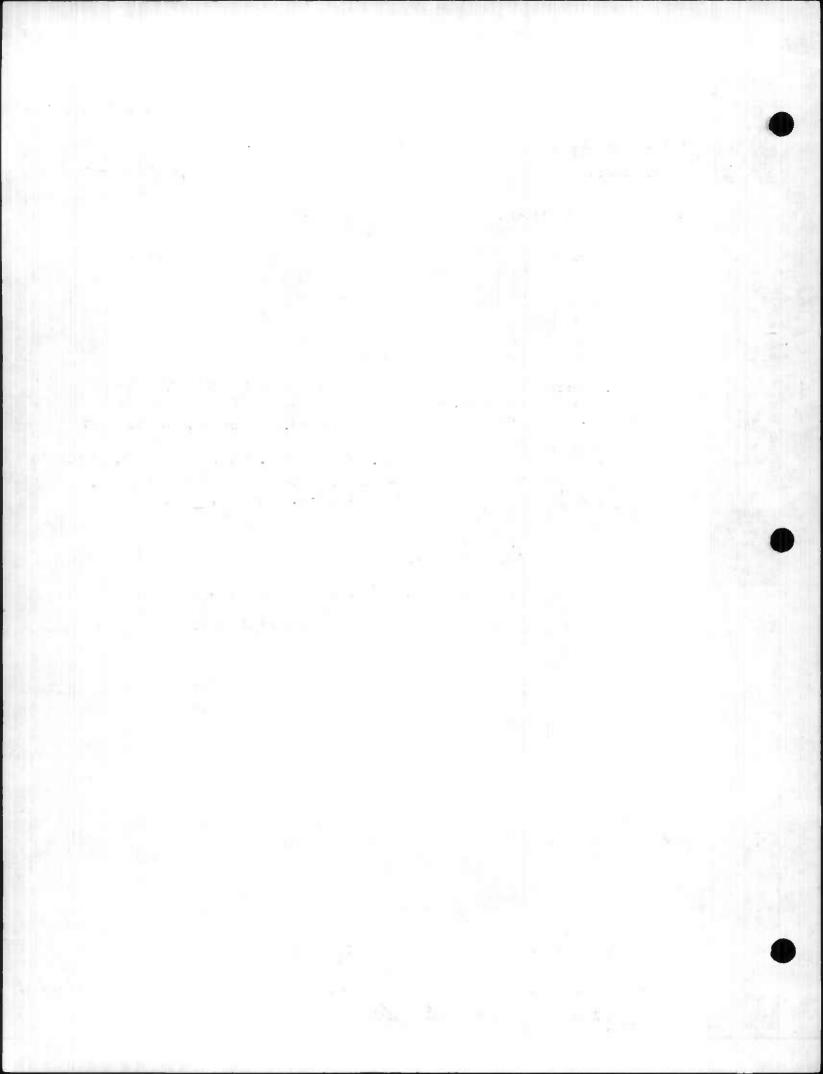
Square

Drive

29d. Dete signed (Month, Day, Year)

21237

Baltimore Maryland



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

If Under 1 Year

10f. Zip Code

Months

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death

Physician	
/Medical	
Examiner	

WILLIAM D. SOMMERVILLE 4a Facility Nama (If not institution, give street and number)

Day 23 JAN. 4b. City. Town, or Location of Death

Month

1999 4c. County of Death

3. Time of Death 10:30am

606 SOMERSET RD.

5. Social Security Number

BALTIMORE

Funeral Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be nothing at

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Completed

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permit. Page Department of Important: If any Injury or

Physician

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Medical Certification: To

The law requires that the death certificate be executed

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e Hospital or Attandi 24 hours after death e Funeral Director: A

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P.O. Box 68760.

Records,

Division of Vitai or Attending Physician:

21215-0020

Baitimore, Maryland

121-24-0467 10a. Stata Director MD 606 SOMERSET RD. Funeral

Usual Rasidanca of Decedant 10b. County N/A 10a. Street and Number

10c. City, Town or Location

7. Aga (In yrs. last birthday)

If Under 24 Hrs. Days Hours

8. Data of Birth (Month, Day, Year) 01/31/1920 Birthplace (Stata or Foreign Country) MAINE

BALTIMORE

21210

1 Yas 2 No Specify:

10d. Inside City Limits 1 Yes 2 No

1 Never Married 2 Married

12. Was Decedent Evar in U,S. Armed Forcas? 1 XYas 2 No If Yas, Giva Yaar or Datas: WWII

Collega (1-4or 5+)

78

1**X** M 2□ F

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.)

USA 14. Race - American Indian, Black White atc

Specify: WHITE

10g. Citizen of What Country?

3 Widowed 4 □ Divorced 15. Decedant's Education (Specify only highest grada complated)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

SALES MANAGER

SALES

17. Fathar's Nama (First, Middla, Last)

WILLIAM D. SOMMERVILLE

LOUISE H. CUSHMAN

18. Mothar's Nama (First, Middle, Maiden Surnama)

Data

19a. informant's Neme/Raletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4800 WILMSLOW RD. BALTO., MD. 21210.

JAN HYDE (DAUGHTER)

20b. Place of Disposition (Neme of cematary, cramatory or other place) 20c. Location - City or Town, State

20a. Mathod of Disposition 1 ☐ Burial 2 【Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

22. Name and Address of Facility

GREEN MOUNT CREMATORY01/25/99 BALTO., MD.

21. Signatura of Funaral Sarvice Licensaa

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

HENRY W. JENKINS & SONS (4905 YORK RD. BALTO., MD. SONS CO

immediata Causa (Final disaasa or condition rasulting in daath)

Cell CencinomA

Approximata Interval Between Onset and Death

Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Causa (Disease or Injury that initiated evants rasulting in daath) Last

Dua to (or as a consequence of)

Dua to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 1 Yes

24a. Wes an autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yas No

26. Place of Death (Check only one)

1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medical axaminer? 1 Yas 25 No 27. Mannar of Death

1 Netural

2 Accident

3 ☐ Suicida

5 Panding Invastigation

6 Could not be datarmined

1 inpatiant 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 28b. Tima of Injury

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

 Pleca of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida 29e. Cartifiar (Check only one)

Certifying Physician: To tha best of my knowledge, deeth occurred et the time, data end place, end dua to tha cause(s) and menner es stated.

Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and mannar statad.

1 □ Yes 2 □ No

29c. License number

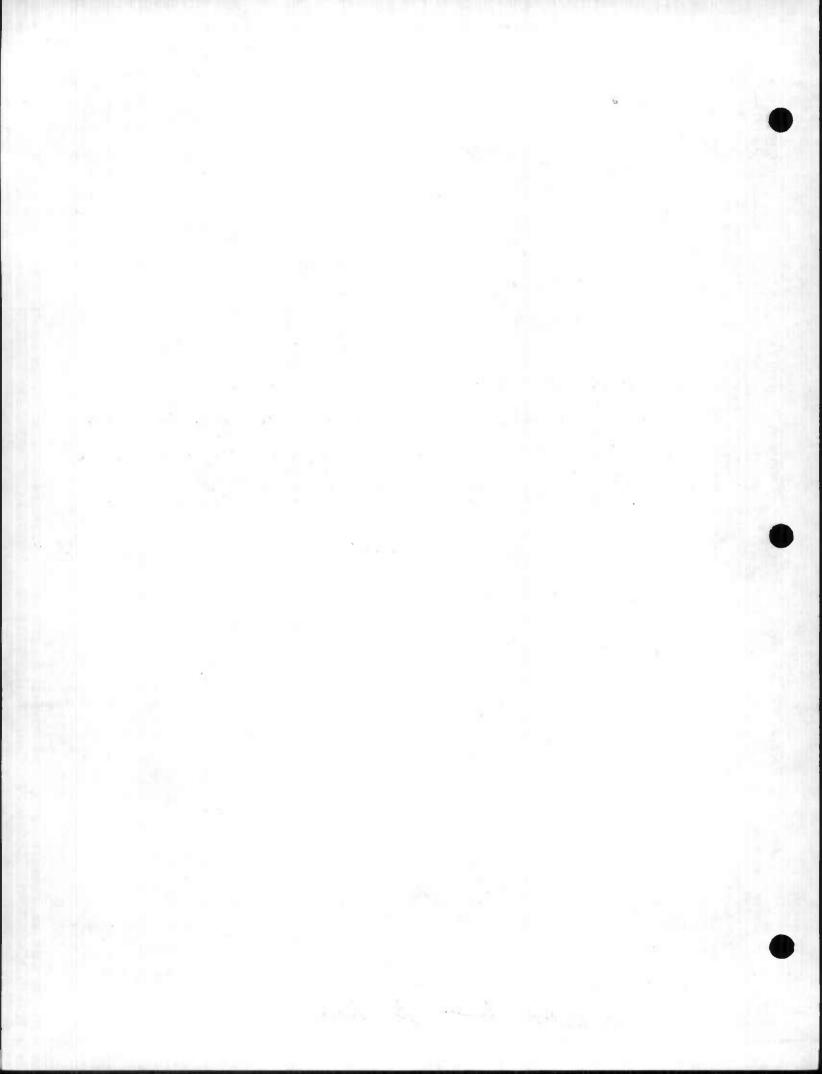
TyPhuy Baltimire MD 21210

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

State

DHMH 16 Rev 6/95

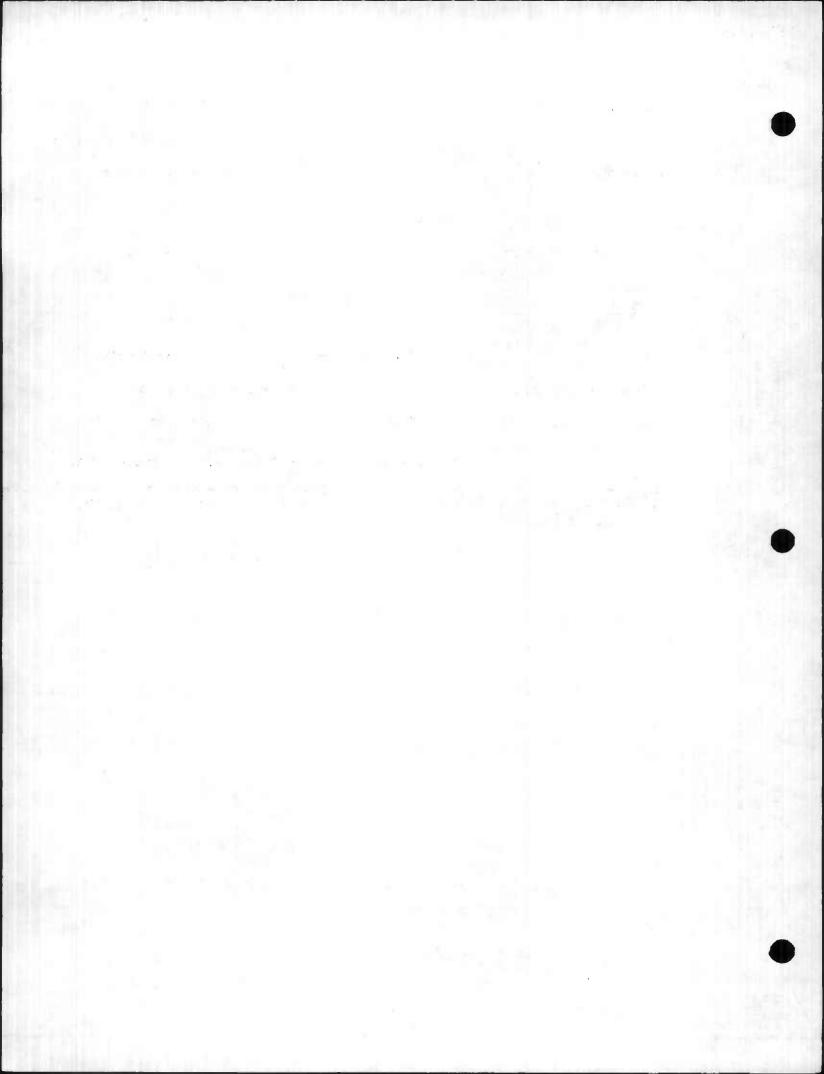
Registrar



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	State of Maryland / Department of Health and Mental Hygiene	U		1	9	5
	Cartificate of Dooth					

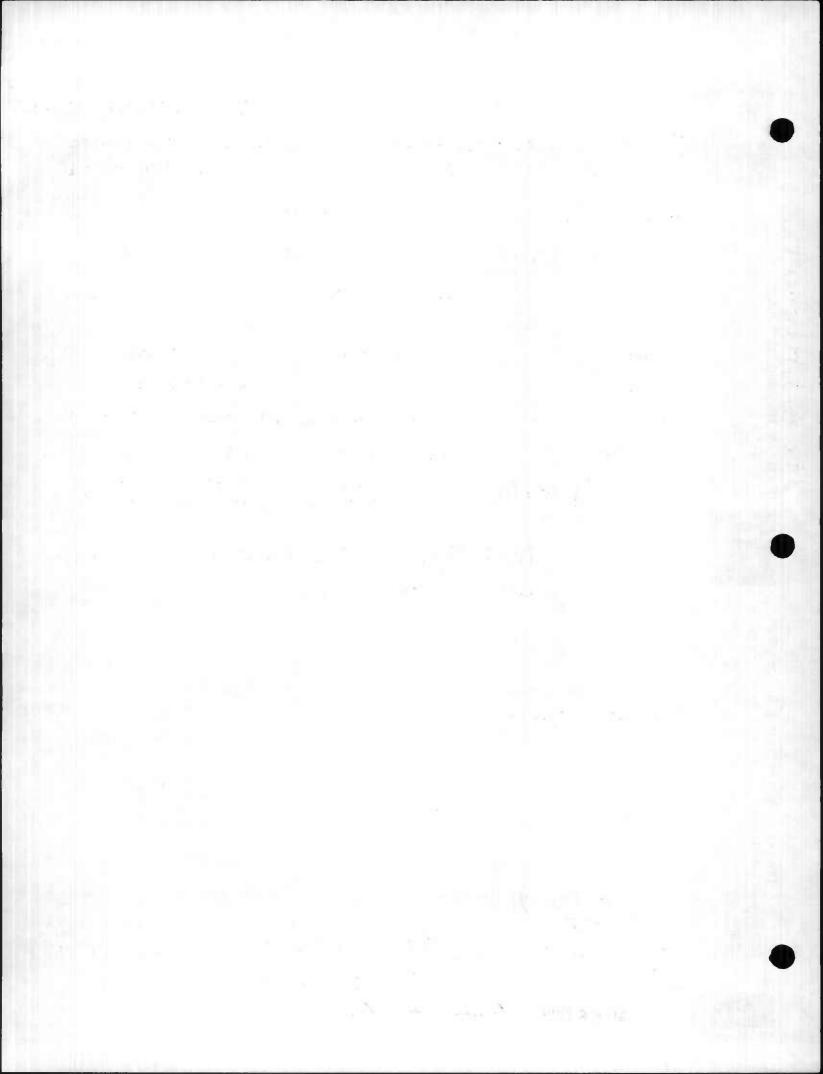
				Cel	rtificate of	Death		Reg. No.		
Physician	1. Decedent's Name (First, M	iddle, Last)					2. Date of D	Peath Day	Year 3.	Tima of Death
Physician /Medical	Gene Leo Smi	th, Sr.					JANUAI			344 PM
Examiner	4a Facility Name (If not institute 6525 BALTIMO)		nber)				ORE CITY	,	of Death	
Funeral Director	5. Social Security Number 161-22-9405	6. Sex 1∰M 2□ F	7. Age (in yrs. las 68	t birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, L	irth (2ay, Year)	Country)	(State or Foreign
P .	Usual Residence of Decedent 10s. State 10b. Cou		40a Chu	Town or Lo	antion				Land	
h the Merylan r 28a-f abov inotitied at frector		/A		Ltimo						nside City Limit Yes 2□N
5 0 D	10e. Street and Number 6525 Baltin	ore Avenue			101. Zip Code 212	22		10g. Citizen of V		
ura efter al', or he minne by Fur	11. Marital Status 1 Never Married 2 1 Nover Married 2 Nover Married 2 1 Nover Married 2 1 Nover Married 2 Nover Marrie	Armed For 1 TYPES If The Give	2 □ No		Was Decedent of f Yes, specify Cul		n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rac Blac Specify	ce - American Inck, White, etc. White	
n 72 hours "natural", of election		dent's Education		16a. Dece	dent's Usuel Occu kind of work done	pation	of working	16b. Kind of B	usiness/Industry	
i within liane.	Elementary/Secondary (0-1		4or 5+)	life. I	NOT use retir	ed)	a working	Car Ca	arrier	
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a 1 and 2 about be filed than 27 is marked other other traumatic avent. To Be Cc	Clarence	Leo Smith				E1e	enor Bride	get Fusco	0	
2 should and Men is merke surredo	19a. Informant's Name/Relati	onship (Type, Print)		19b. Mailir	ng Address (Stree	and Number	or Rural Route Num	ber, City or Town,	State, Zip Code	9)
1 and 2 Health em 27 le ither tre	Betty E.	Smith/ Wife		652	5 Baltim	ore Ave	e., Baltir	nore, Md.	2122	2
90-x	20a. Method of Disposition 1 ☐ Burial 2 💆 Cremeti 4 ☐ Donation 5 ☐ Othe		State cen	netery, crei	sition (Name of netory or other plane		1-22-99 Crematory	- 6	City or Town, S	
parlmant portant: portant: y hjury o	21. Signature of Funeral Serv		Date		. Name end Addr		Heliatory	La	mer, m	
Dep para ana	23a. Part1. Enter the disease shock, or heart failure.	Tengran	al h.	Br	adley-As	hton-Da	abrowski-R ng Rd., Ba	altimore		
Physician /Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	a	Due to (or a	Gu is a consec	Juence of):	trous	208H	rad	Ons	et end Deeth
the death cartificate be associted by the attending physician and solved for use as the burial-transit hysician/Medical Examinar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or a							
at the death ca d by the attendi etached for use Physician/	Part II. Other significant cond	litions contributing to dea	ath but not resulti	ng in the u	nderlying cause g	iven in Pert I.	23b. Di	d tobacco use co	ntribute to the	cause of dear
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s been 2 should				4			24a. Wa	is an autopsy formed?	availabl	utopsy findings e prior to tion of cause 1?
4 - 5 -							1	Yes 2□No	Do Yes	2 □ No
cartificata rector, pag Be Co	25. Was case referred to med	ical	4			26. Place o	of Deeth (Check only	one)		
Physician: this cartific ral director, TO Be (examiner? 1)XXYes 2 □ No	Hospital:	patient 2 EF	VOutpatier	N 3 DOA	ther: 4 Nurs	ing Home 5 XRe	sidence 6 Oth	ner (Specity)	
	27. Manner of Death 1 Natural 5 Per 2 Against investigation	ading 28a. Date of (Month / 20)	f Injury h, Day Year)	8b. Time of	W	uny at ork? Yes 201N	Coch	how injury occur	-selt	0
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral Medical Cartification:	3 Suicide 6 □ Co	ald not be armined 28e. Place of building	of Injury - At homing, etc. (Specify)	11-	eet, factory, office		28f. Location City or T	(Street and Numi	ber or Rural Rou	ite Number,
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To the within To the compl	29b. Signature and title of cer		mo			ise number		29d. Date signe JANUARY		
DED.	30. Name and address of pers	WIFE, 1	A /1			altimo	re, Maryla	and 2120	1	
State Registrar	31. Date filed (Month, Pay Ye	2 6 1999 32. Re	ogiatrar's Signetur	· B	Spar	Val.				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth January 3, 1999

Ocation of Deeth 4c. County of Death **Physician** 9:28 A.M Herbert Stewart /Medical 4a Fecility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth Examiner Os edale Under 24 Hrs. 8. Deta Baltimore Franklin Square Hospital Center
5. Social Sacurity Number 6. Sex 7. Age fin yrs. last birthdey) It Under 8. Deta of Birth (Month, Day, Year) JULY 10, 1910 Birthplece (State or Foreign Country) **Funeral** 15 M 2□ F Months 88 Virginia 217-05-1661 Director Usual Residence of Decedent 10a. Stete 10d. Inside City Limits 10b. County 10c. City, Town or Location remember oner then "natural", or ferms 23a or 28e-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Baltimore Maryland N/A Director 10e. Street end Number 10a. Citizen of Whet Country? 10f. Zip Code 21206 USA 6116 Bel Air Road by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Yeer or Dates: WWII 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, tewart, Herber Bleck, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 ☐ No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) Peges 1 end 2 should be filed within nent of Health end Mentel Hygiene. int: if item 27 ie marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer Unk. 18. Mother's Nema (First, Middle, Meiden Sumeme) 17. Fethar's Nama (First, Middle, Last) Mozella Miles Unk. 19a. Informant's Neme/Retationship (Type, Print) 19b. Maiting Addrass (Straat end Number or Rural Route Number, City or Town, Stete, Zip Code) 3434 T4 Carriage Hill Circle Randallstown, MD 21133 Linda Harden/niece 20b. Place of Disposition (Name of cemetery, cremetory or other place)
Metro Crematory Inc. 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriat 2X Cremetion 3 ☐ Removel from State 6 1/23/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Furreral Service Licenses $^{22.\;\text{Name end Address of Fecility}}$ Cremation Society of Maryland Inc. J. W. S. 299 Frederick Road 21228 Baltimore, McDonald 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart faiture. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediata Causa (Final ·Acute Myocardial Intarction disease or condition resulting in death) HOUR Examiner Examiner Coronary physician end s the buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated avants resulting in deeth) Lest Dua to (of es e consaquence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown signed by t Meumonia Aspiration 24b. Were autopsy findings evaitable prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 TYes 2 No Hospital or Attending Physicien:
 24 hours efter death.
 Funeral Director: After this certific. 25. Wes cese referred to medical axaminar?

1 ☐ Yes 2 No director. Be 26. Placa of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannar of Death 28e. Data of tnjury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 1 Naturel 2 Accident 5 Pending investigation 2 No 3 Suicida 6 Could not be Location (Streat and Number or Rurel Route Number, City or Town, State) Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Medical Examinar: To tha best of my knowladga, daath occurred et the time, date end plece, end dua to the ceuse(s) end menner as stated. On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, dete and piece, and dua to tha causa(s) and manner stated. edicai 29e. Cartifier To the To the To the 29d. Date signed (Month, Dey, Year) 29b. Signature end title of ceg 29c. License number January 21, 1999 me and addrass of parson who complated causa of death (Itam 23a) [Type, Print) Road ford Baltimore, MD 21214 LU 32, Registrer's Signature 31. Dete tiled (Month, Dey, Year) State JAN 2 6 1999 Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $9\,9\,$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 45 WILLIAM 99 SEEBERGER JAN 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY HOSPITAL BALTIMORE BALT CITY If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours Davs 1XM 2 F 220-36-2274 58 01 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits SHORE LAKE MD Anne Arundel 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 2920 LADY ASTOR COURT USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2K No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Warehouseman Tool Company 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First Middle, Maiden Surname) Frances M. Price Lawrence J. Seeberger 19a. Informent's Neme/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Seeberger wife 2920 Lady Astor Court Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removat from State 1/28/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 21. Signalura of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Home P.A. Part 1. Enter the distance of polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. Baltimore, Md. 21225 Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) septic shock platelet transfusion reaction bronchiolitis Due to (or es a consequence of):

Physician /Medical Examiner

physician and the burial-transit

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signed by the a

funeral

the death certificate be executed

or Attending Physician: The law requires that Division of Vital Records.

death. s after death 2 ri pelli 24 hours

within 24 hor To the Fune completely fi

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Box 68760.

P.O.

nt of Health a : If ham 27 is

permit. Pege Department of Important: If any injury or pace.

Physician

/Medical

Examiner

Funeral

Director

Show

r than "natural", or herms 23s or 28s-f ahov the Medical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or home 23e or

Baitimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

the Manyland

Examiner Physician/Medical þ Completed Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CUTE LYMPHOGYTIC LEUKEMIA Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?

				1 □ Yes 21 No	3 Probably 4 Unknown
				24a. Was en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				15 Yes 2□No	1 □ Yes 2 No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
axaminer? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient 2 [☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 Residence 6 □Oth	er (Specify)
27. Menner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not be determined		nome, farm, street, fac fy)	tory, office	281. Location (Street and Numb City or Town, State)	per or Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exam	nysician: To the best of my known inner: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date and plac ion, in my opinion, deeth occ	ce, and due to the cause(s) and ma curred et the time, date end plece,	anner as stated. and due to the cause(s)

29c. License number

DO053538

29d. Date signed (Month, Day, Year) JAN 23, 1999

10

State Registrar

edical

RANNGER 31. Date filed (Month, Day, Year) JAN 2 5 1999

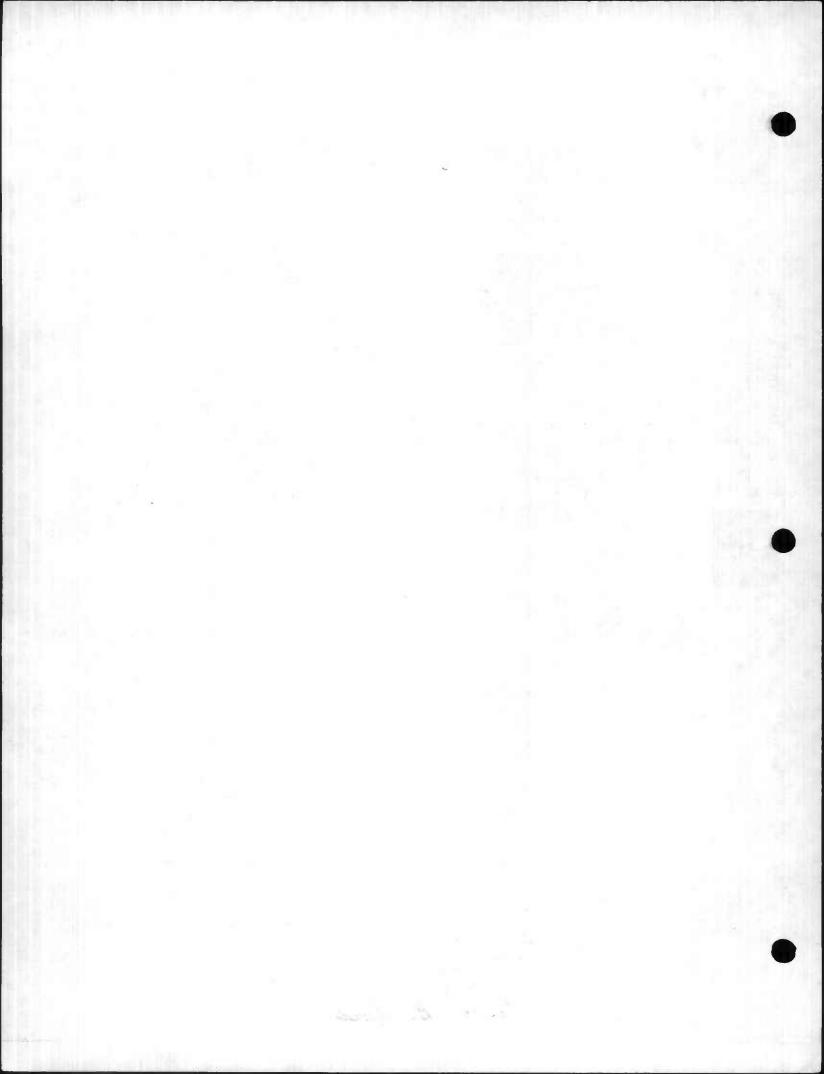
29b. Signature and little of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 GRIDURY LN SINER SPRING, MD

Mar

32. Registrar's Signature

oach



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Deeth 20, 1999 Month Tsien Vee Chang 0205am January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Howard County General Hospital Howard 9. Birthplace (State or Foreign Country) Columbia If Under 1 Year 8. Date of Birth (Month, Day, Ye May 26, 1 Age (In yrs. last birthday) 1 M 2□ F Days 326-28-8450 81 Yrs China 1917 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyes 2 NO No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road 21045 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Chinese 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) mechanical engineer engineering 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ching Tsien 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5022 Cloudburst Hill, Columbia, Md. 21044 Christopher C. Tsien, son 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore/Washington Crem. 1/22/99 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licenses 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, Md. 21045 semmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MINUTES Arry tenning Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to 1 solure Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probabty 49 Unknown 1 ☐ Yes 2 ☐ No AMPIC MERLYM 24b. Were autopsy findings eveilebie prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 O 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: ✓ Inpatient 2□ ER/Outpatient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 300 28a. Dete of Injury (Month, Day Year) Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, tactory, offica building, etc. (Specify) 4 Homicide

Examiner physician and P.O. Box 68760. Physician/Medical attanding 0 the 2 signed t Records, þ Completed page 2 Division of Vital Be Certification: To

Physician

/Medicai

Examiner

Funeral

Director

28a-f show

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death

Director

Funeral

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Completed

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other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iter any injury or other traumaths.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: Aftar this certifica completely filled in by the funaral director,

State Registrar

Medical

29a. Certifier

29b. Signature and of certifier

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 11053 the Dete tiled (Month, Day, Year)

Portuger 32. Registar's Signature

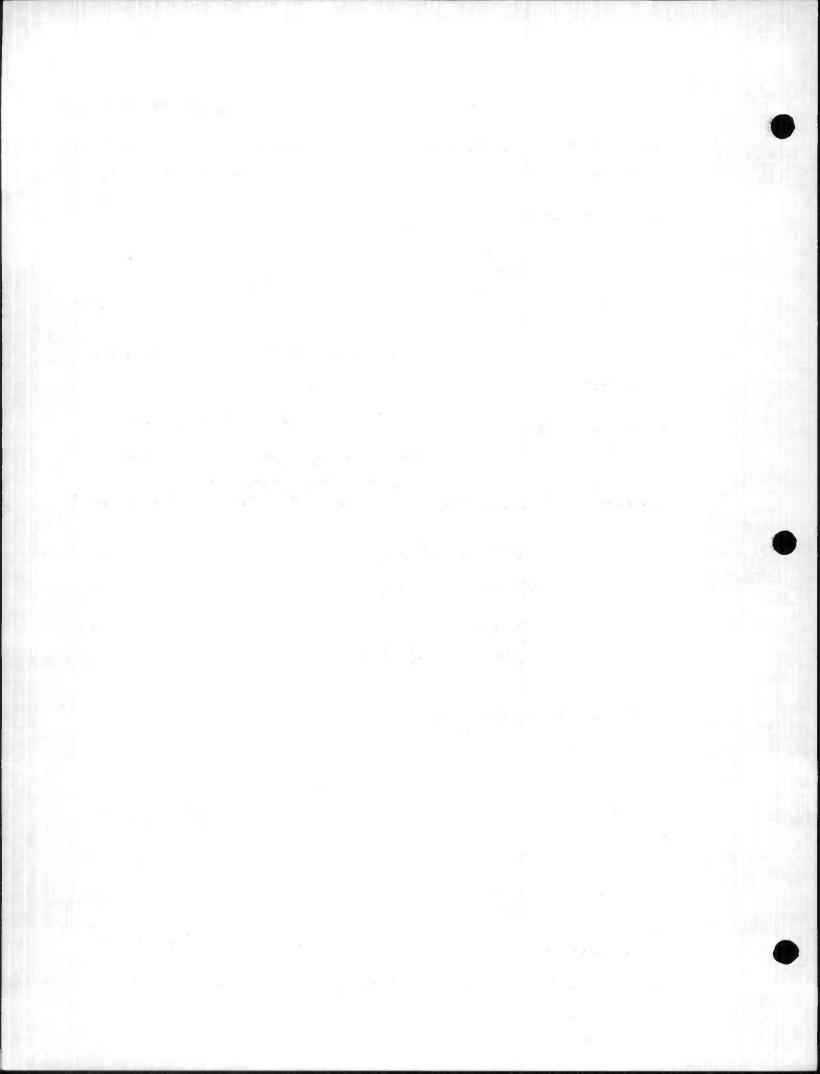
1 ertifying Phyalclen: To the best of my knowledge, death occurred at the time, date end piace, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, end due to the cause(s) and manner steted.

29c. License number

Colubra, MO

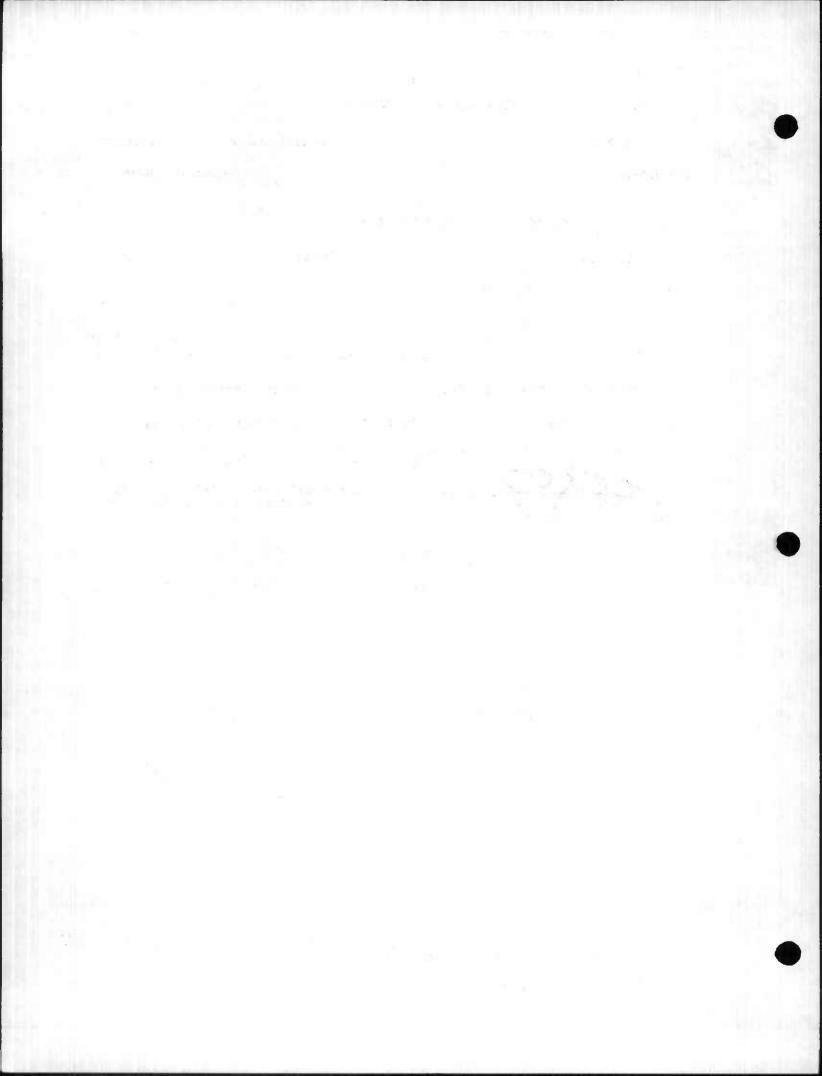
29d. Date signed (Month, Day, Year)

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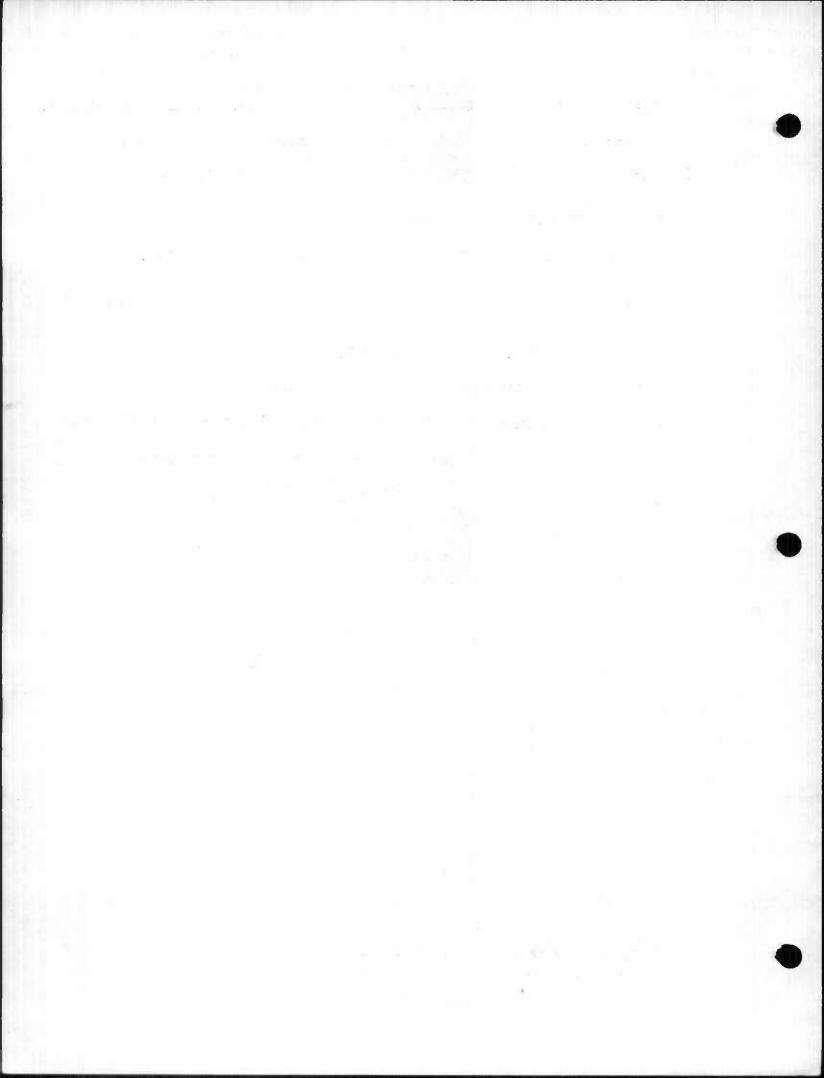
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

	1. Decedant's Nama (First, M	and the same of th	Name of the	C 1367		2. Data of Deat Month	and the same of th	3. Tima of Death
Physician /Medical	M.	E1	izabeth	Thomps	on	I I	22 19	99 2:10pm
xaminer	4a. Facility Nama (If not institu	ution, give street and nu	mber)		4b. City, Town, o	Location of Death	4c. County of [Death
	BROADMEAD				Cockeys		Baltim	
	5. Social Sacurity Number 579-60-3416 Usual Rasidance of Decedent	6. Sax 1 □ M 2 F	7. Aga (In yrs. last bi	Yrs. If Undar Months	1 Year If Under 24 Hr Deys Hours Mit		^{Year)} 29,1905	Birthplace (Stata or Foraign Country) NJ
	10a. Stata 10b. Cou		10c. City, Tow	n or Location				10d. Inside City Limits
ecto		ltimore	Cocke	ysville				1 ☐ Yas 2 ☒ No
ai Dir	10e. Street end Number 13801 York Ro	ad		10f. Zip	21030	1	0g. Citizen of Wha	
by Funeral Director	11. Maritai Status Never Merried 2 M Widowed 4 Divor	Armed Fo	2X□ No va		ant of Hispanic Origin? (fy Cuban, Maxican, Pus X No Specify:	Specify Yas or No- rto Ricen, atc.)		American Indian, Whita, atc. hite
Be Completed	15. Dece (Specify only hig Elemantary/Secondary (0-1		1-4or 5+)		k dona during most of w a retired)	orking	16b. Kind of Busin Public L:	ibrary
S	17. Fathar's Name (First, Midd	de Last)	Chi	ldren's I	Librarian	ama (First, Middle, M	of Washi	ngton
To Be	Henry Creigh		on, Sr.			e Armstro	· · · · · · · · ·	r
	19a. Informant's Name/Relati	onship (Type, Print)	198	o. Mailing Address	(Street and Number or F			
	William M. Le	vy/Attorne		09 Bosley	Avenue T			
	20a. Mathod of Disposition 1 Burial 2 Cramatic 4 Donetion 5 Other	on 3 Ramovel from (Specify)	Stata Baltim	ore Washi rematory ocot rematory	a or bar placa) ington	Jan. 23 1999	20c. Location - City Laure	
eny injury or other traumatic event, the Madical Examiner must be notified at once. To Be Completed by Funeral Director	Michael J	lag1e		Lemmon	Address of Fecility Funeral Horadonia Roa	me of Dul	aney Vali	ley, Inc.
ian ical ner	Immediate Causa (Final disease or condition rasulting in deeth)	ist only one cause on a	MYOCA		/NFAR	CTION	V	Approximate interval Between Onset end Death
cai Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disaase or injury that initiated events	5 b		1/C H consequence of):	EART	DISEA	56	10yr
Physician/Medical Examir	rasulting in death) Last	d	Dua to (or as a	consaquence of):				
ysici	Part II. Other aignificant cond	litiona contributing to de	eath but not resulting i	n the undarlying ce	usa givan in Part I.	23b. Did to	bacco use contrib	oute to the cause of death?
by Ph	MULT	1-1NF1	9RCT	DEME	NTIA	1 □ Ye	2 ☑ No 3 □	Probably 4 Unknown
Completed	AOR7	70 5	TENO	515		24a. Was er perform		4b. Wara autopsy findings eveilabla prior to complation of causa of daath?
	INTE	RSTIT.	IAL t	-1BR0	5/5	1□ Ye	s 2 No	1 Yas 2 No
To Be	25. Was cesa ratarred to med axaminar? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2□ER/Ou	utpatiant 3 DO/	Other	aath <i>(Check only one</i> Homa 5 Reside		Specify)
n:	Z LI MOCIDAIN	stigation	of Injury th, Day Year) 28b.	Time of 28 Injury M	ic. Injury at Work? 1 Yas 2 No	28d. Describe ho	w injury occurred	
Certifi	4 ☐ Homicida data	buildir	of Injury - At homa, fang, atc. (Specify)			City or Town	, Stata)	r Rural Routa Number,
0	29a. Cartifier 1 Certification (Check only one) 1 Medical	fying Physician: To the cal Examinar: On the be and mann	asis of axamination an	e, death occurred a d/or invastigation, i	t tha time, date and place In my opinion, death occ	e, and dua to tha ca urred at the tima, da	iuse(s) and manne ata and place, and	or as stated. due to the ceuse(s)
dic o					I faces a south or	20	nd Data signed /h/	tout Day Vand
completely filled in by the fur Medical Certificatio	29b. Signature and titla of cert	usa Ga	rroll	mg) 29c.	D3839	2	1/2	fonth, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth Month **Physician** 24, 1999 ALMA RICHARDSON TALTAFERRO January 6:10 P.M. /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Towson **Baltimore** Pickersgill If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) May 25, 1898 9. Birthplece (State or Foreign Country)
Virginia 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** Days 1□M 2∏F Yrs 100 213-74-2163 Director Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10e Stete 10h County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryle neat of Heelih end Mentel Hygiene.
Int: If item 27 is marked other than "naturel; or items 23a or 28a-f show many or other than the notified any or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 21 No Director Baltimore Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 615 Chestnut Avenue 21204 Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) School Teacher years Education 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Richardson Bertha Blunt. David 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4513 Harwich Terrace Upper Marlboro, Maryland 20772 Anne Mitchell (daughter) 20b. Place of Disposition (Name of cometery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Depertment of freportant: If any Injury or once. 1-26-99 Baltimore, Maryland Green Mount Crematory 22. Name end Address of Fecility
Mitchell-Wiedefeld Home, Inc. 21. Signeture of Funerel Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner Examiner Hospital or Attending Physician: The lew requires that the death certificate be extegled Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): detached for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yee 2 XNo 3 Probably 4 Unknown nveT dementia Aq director, page 2 should be 24b. Were eutopsy findings avellable prior to Be Completed 24e. Wes en eutopsy performed? completion of cause of death? certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending investigation 1 Yes 2 No To the Hospital or Attendit within 24 hours eftar death. To the Funeral Director: A 2 Accident filled in by the 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier completely 29b. Signature and title of certific 29c. License number 29d. Dete signed (Month, Dey, Year) und who completed cause of deeth (Kem 23e) (Type, Print) 6701 N. Charles St. Balto. md 21204 6.BMC 31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture State Registrar porks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 105340 SANUARY Louis C. F. Van Ael 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Mercy Medical Center Baltimore N/A If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign XXM 2DF Belgium 083-18-3838 84 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore 1 XYes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1101 St. Paul Street 21202 USA #2205 12. Was Decedent Ever in U.S. Armed Forges? 1 ☐ Yes A ANO If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 21X Married 1 Yes 2 No Specify: white Specify 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation (Gave kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-for 5+) Engineering Marine Engineer 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Midrile Last) Unknown Marie Deshryver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 1101 St. Paul Street Baltimore, MD 21202 Apt.2205 Bettie King Van Ael (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/25/99 Hilltop Service Co. Towson, Maryland 22. Name and Address of Facility Burgee-Henss Funeral Home, P.A. 3631 Falls Road Baltimore, Maryland 21211 sylale Herss! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Box 68760.

P.O.

of Vital Records,

Division or Attending **Physician**

/Medical

Examiner

Funeral

Director

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Norms 23a

'natural', or

Hygiena.

Papes 1 and 2 should be fill ment of Health and Mental H sant; if Nem 27 is marked off

permit. Pages 1 and 2. Department of Health a. Important: if them 27 is any injury or other trai-anse.

Director

Be

Physician/Medical Examiner à Completed Certification: To Be

1 Yes 25 No

27. Manuer of Death 1 SNatural 2 ☐ Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signeture and title of certifier

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one STE //#

28a. Date of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nanknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

MARIS AT MERC Other: 4 Nursing Home 5 Passidence 6 Nother (Specify) HOSpice 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes 2 200

r Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

29c. License number D 40854

28c. Injury at Work?

1 Yes 2 No

JANUARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG 301 St.

DAVID 31. Date filed (Month, Day, Year)
JAN 2 6 1999

5 ☐ Pending investigation

6 Could not be

32. Registrer's Signature Geneva

PI, BAHIMORE, MD 2/202

State Registrar

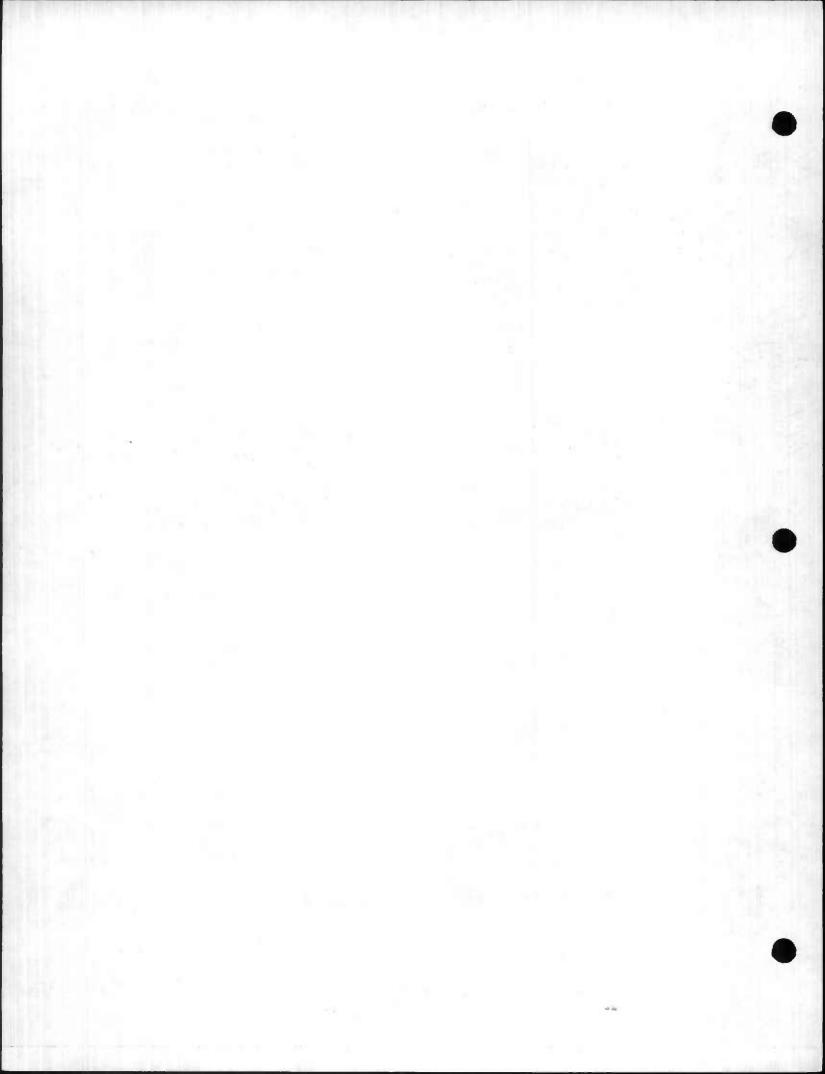
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Medical		If not institution, give		10111	· Seen	4b. City, Town, or	JANUA Location of Deat		41.
niner		WEST H		CEN	TER	RANDA		4	1471110
	5. Social Security I		-	e (In yrs. last birtl					9. Birthplace (State o
	212-03-61	109	DM 2□F	OF	rs. Months Day		Oct.	10,1903	Mary land
	Usual Residence of	10b. County		10c. City, Town	or Location				10d. Inside Cl
	Md.	Baltimo	re		ngs Mills				1 🗆 Yes
dileial Dilectol	10e. Street and Nu 1072	omber 29 Park He	ights Ave	•	10f. Zip Code			10g. Citizen of V	What Country?
era	11. Marital Status		12. Was Decedent	Ever In U,S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (S	pecify Yes or No	o- 14. Race	e - Americen Indian,
	1 Never Man	ried 2 Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No	1 Tes, specify Cu		o Hican, etc.)	Specify	White, etc.
		15. Decedent's Ed	CONTRACTOR AND ADDRESS OF	16e.	Decedent's Usual Occ	upation		16b. Kind of Bu	isiness/Industry
		cify only highest gree	fe completed)		Decedent's Usual Occ 'Give kind of work don life. DO NOT use retii	e during most of wo	rking		
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		(First, Middle, Last)	ard Valen	tine			ne (First, Middle	, <i>Melden Sum</i> em L n	Θ)
0		lame/Reletionship (7)			Meiling Address (Stre	et end Number or Ri	rel Route Numb	er, City or Town,	State, Zip Code)
		. Reynolds			2 Bond Ave				
	20a. Method of Dis			20b. Place of	Disposition (Neme of		Date	20c. Location -	City or Town, State
		☐ Cremation 3 ☐ 5 ☐ Other (Specify		Lorrain	cremetory or other p	n. Jan. 2	9, 1999	Baltimo	ore, Md.
	21. Signature of F	uneral Service Licens	og de		22. Name and Add	ress of Facility Funeral	Thenel		21117
	1	14.2d	harde		11605 Re:	isterstown	a Rd.	wings Mi	Ils. Md.
	23a. Part1. Enter shock, or her	disease, or comp	lications that ceused ne cause on each li	the death. Do n	ot enter the mode of d				Approximate Interval Bet
		100							Onset and I
	Immediate Ceuse disease or condition resulting in death)	on	a	PNE	OMO	NIA			DA.
L-	resulting in death)			Due to (or as a c	onsequence of):				
Examiner			b						
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2	resulting in death)	Last		Due to (or as a co	ensequence of):				1
NMedical			d						
SICIA	Part II. Other signi	ificant conditions co	ntributing to death b	ut not resulting in	the underlying ceuse	given in Part I.	23b. Did	tobacco use cor	ntribute to the cause
Physicia							1□	Yes 2 No	3 Probably 4 €
Dy									
Completed t							24a. Was perf	s an autopsy ormed?	24b. Were autopsy to available prior to completion of comp
-							10	Yes 2 No	of death?
000	25. Was cese refe	rred to medical				26 Place of De	eth (Check only	one)	
0	examiner? 1 ☐ Yes 2X		Hospital:	ent 2 ER/Out	patient 3 DOA	Where		idence 6 Oth	er (Snecity)
	27. Manner of Dea		28a. Date of Inju (Month, De					how injury occur	
	1 Natural 2 Accident	5 Pending Investigation	(Month, De	y Year) In		/ork? ☐ Yes 2☐ No			
Se concentrations	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At home, far c. (Specify)	m, street, factory, offic	e		(Street end Numb own, Stete)	per or Rural Route Nurr
	29a. Certifier				death occurred at the				
	(Check only one)	2 Medical Exam	and manner st		or investigation, in my	y opinion, death occi	arred et the time	, date and piece,	and due to the ceuse(s
	29b. Signature and	d title of certifier	1	ı- A	29c. Lice	nse number		29d. Date signe	d (Month, Dey, Year)
		1.1	1<.2	.RAO.	LID. D	4346	2 1	JANUA	RY 25,
	30. Name and edd	ress of person who o	ompleted cause of o	leath (Item 23a) (Type, Print)	S.RA	0.17.	P .	
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e i	31. Date filed (Moi	nth, Day, Yeel?	32. Regist	Gignature					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death WILMORE WHITE Month **Physician** 10 AM 04 MAN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Hopkins IOHNS If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplace (Stete or Foreign Country) **Funeral** Hours H-7018 HOM 20 F 16 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits THES 2 No BALHNER larylow Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2/2/3 U5A 2234 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. Biack, White, etc. ⊅ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1□ Yes 2XNo Specify: WWIL Black à 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) DISINERU ruck Driver grode 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be White DEWEY Midlet Jones 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ava 3902 plaken, ked 3/2/1 W Dought mengo USILEE TY EDERICK 20b. Piece of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, State 20a. Method of Disposition Buriei 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) Vete rous Cin 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAIA THE AN-5240 REISTERSFOUN RIAD 23a. Part Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervai Between Onset and Death Physician -/Medical immediate Cause (Final eaks disease or condition resulting in death) Examiner Examiner COVOY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last ears Dia Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes en autopsy performed? Completed 2 2No 1 Yes 2 No 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stele) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) end manner as stated. edical

Division of Vital Records, P.O.

sician and burial-transit physician s the buriel signed by t After this To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af

the Medical Examiner must be notif

Marrie 23a or

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Saltimore, Maryland 21215-0020

it. Pages 1 and 2 should be infrment of Health and Mental ntant: if them 27 is marked o

State Registrar 31. Date filed (Month, Day, Year) JAN 2 6 1999

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 0

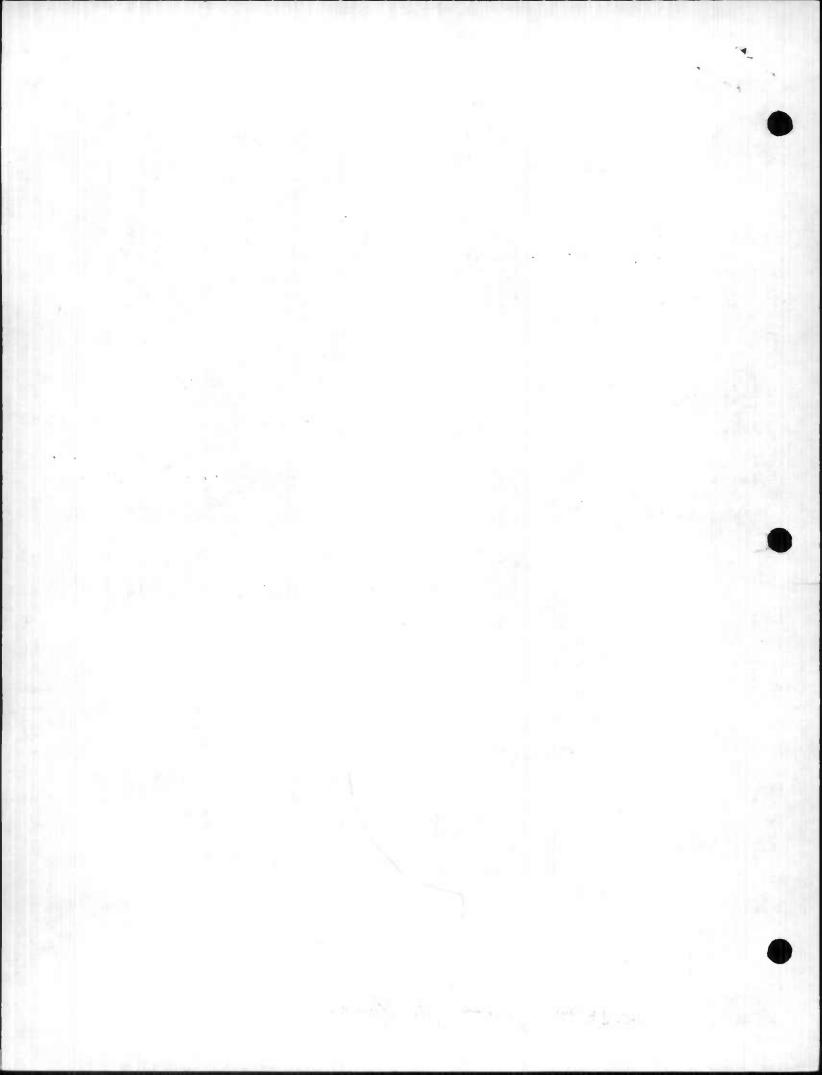
32. Registrar's Signature

3. amahony,

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

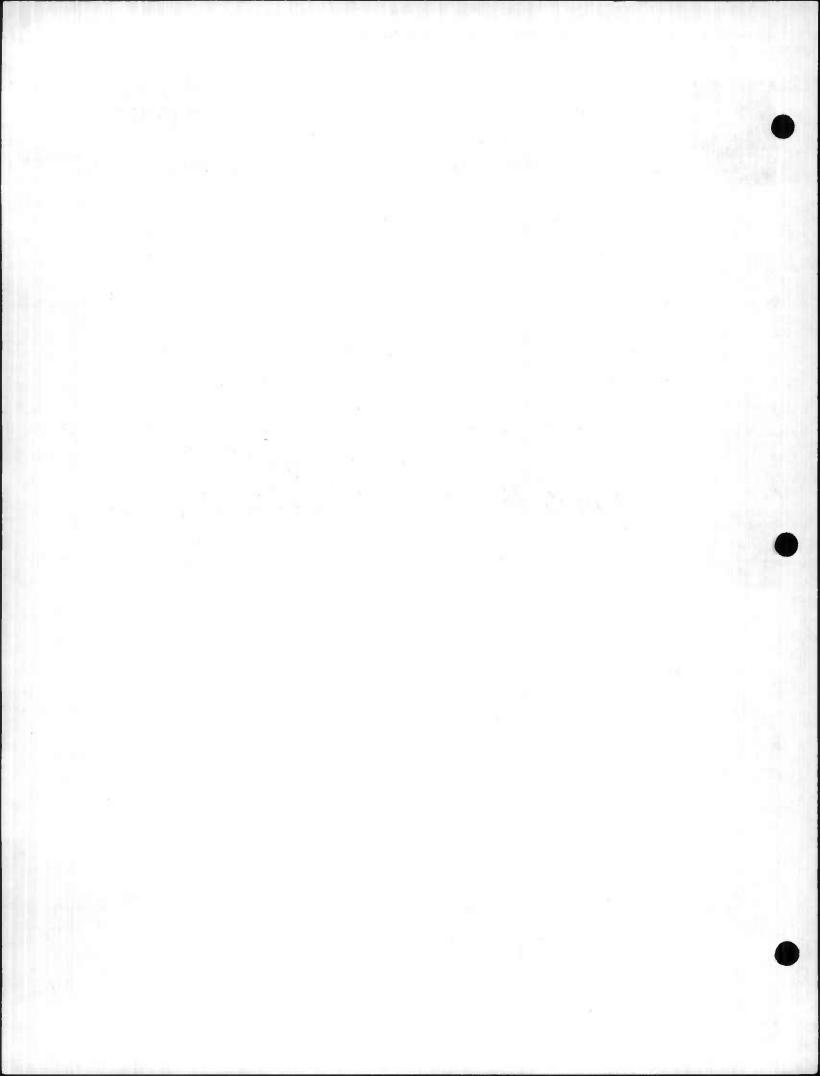
January



DHMH 16 Rev 6/95

Registrar

JAN 26 1999



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Hilda Marie Willeke 22, 1999 8:45pm January 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Genesis Elder Care, 9109 Liberty Road Randallstown Baltimore if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 212–10–8846 6. Sex Birthplace (State or Foreign Country) Months 1 M 200 Maryland August 13,1917 81 Usual Residenca of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1912 Beverly Road U.S.A. 21228 12. Was Decedent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Specify: White 1 Yes 25tNo Specify: 3 ₩idowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Harry V. Dawson Mahaily Danson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1912 Beverly Road, Catonsville, MD 21228 Patricia A. Mabe (Daughter) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/26/99 Baltimore, MD New Cathedral 21. Signeture of Funeral Servica Licensee 22. Neme and Address of Facility Witzke FUneral HOmes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Ceuse (Final disease or condition resulting in death) terioscierosis Years Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequença of): 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funerai

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Completed

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23s or 28s-f show any injury or other traumatic event, the Modical Examiner must be notified at the Bonds.

Baltimore, Maryland 21215-0020

Examine and I-transit requires that the death certificate be executed physician a Physician/Medical attending pl for use as t signed by the a þ Completed s certificate hes b Physician: director, Be To this funeral Certification: After Hospital or Attending 24 hours after death.

P.O. Box 68760.

Division of Vital Records,

death.

To the Hospital within 24 hours a To the Funeral Completely filled

Director: /

filled in by

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Part II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.

24b. Were autopsy findings aveilable prior to completion of cause of deeth?

1 Yes 2 No

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 5 Pending investigation 2 Accident

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. License number D0020964 29d. Date signed (Month, Day, Year) January 25, 1999

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall Randallstown, MD 21133 31. Date filed (Month, Day, Year)

State Registrar

JAN 26

6 Could not be

3 Suicide

29a, Certifier

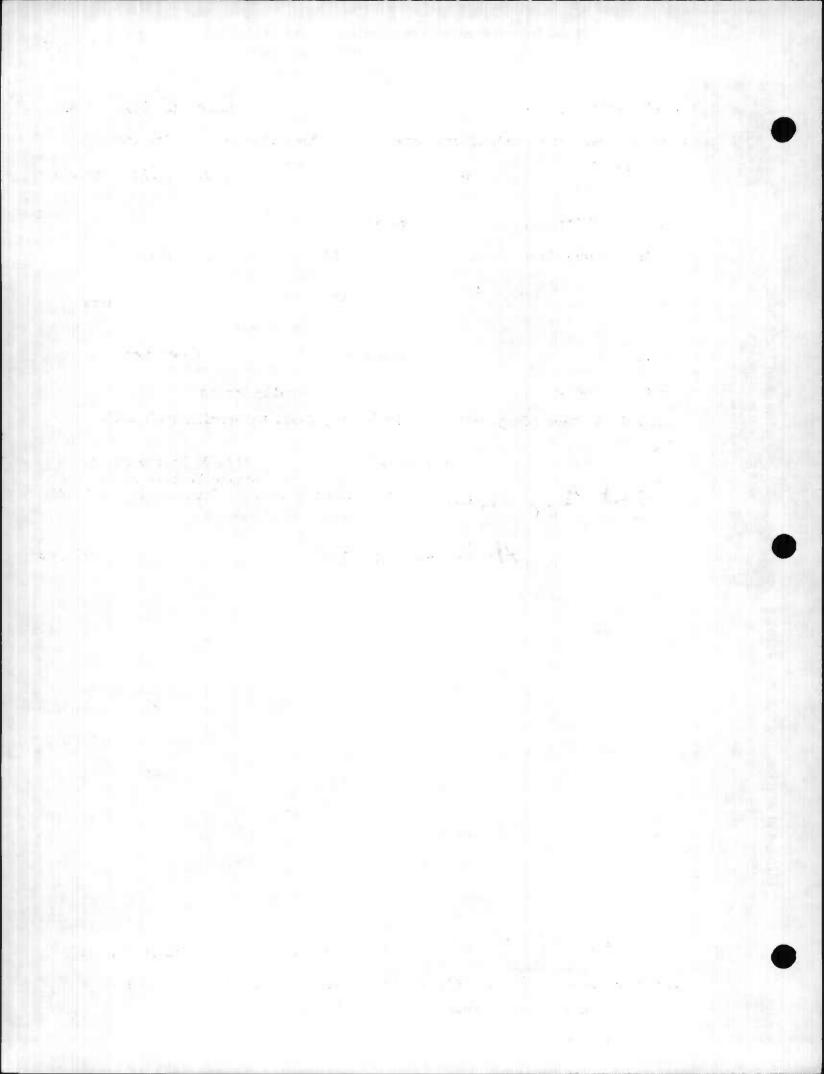
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32. Registrar's Signature

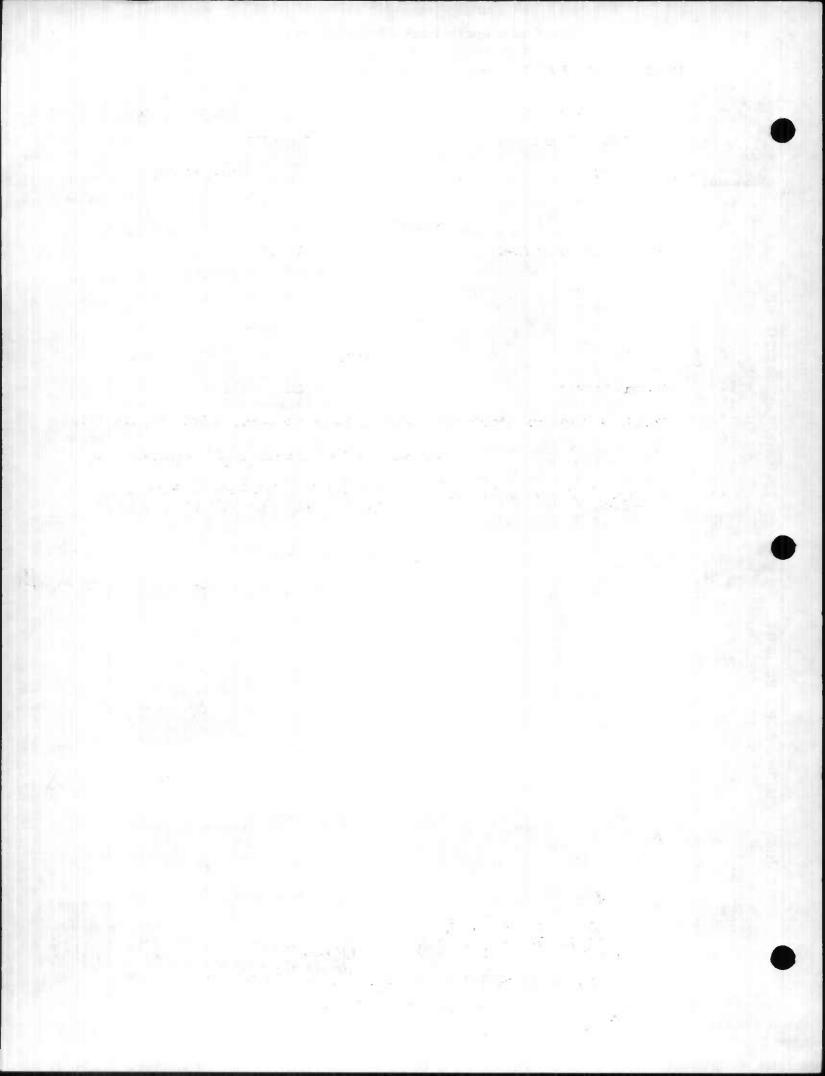
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	Item: 26 per M.D G-767 1/26/99 reb Certificate of Death	R	eg. No.	
Dhysisian	1. Decedent's Name (First, Middle, Last)	2. Dete of Dee Month	th Dey Year	3. Time of Death
Physician /Medical	SYLVIA M. WINTERS	January		5:30 pm
Examiner		, or Location of Deeth	4c. County of Dee	th
	3527 E. FAIRMOUNT AVE. BALTTI 5 Social Security Number 6 Sex 7 Age (In vrs. lest hirthday) If Under 1 Year If Under 24		N/A	
Funeral Director		Hrs. 8. Date of Birth (Month, Dey June 0	7 Year) 9. Bli 5 1939 0	thplace (State or Foreign ountry) hio
arylend show	10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
the Maryle northed show	Md. n/a Baltimore			1 X Yes 2 □ No
With Will	10e. Street end Number 3527 E. Fairmount Ave.		log. Citizen of Whet C USA	ountry?
		7 (Specify Yes or No- Puerto Rican, etc.)		
15- n 72 n 72	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)	f working	16b. Kind of Business	/Industry
	11 0 checker		A&P	
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Maryland d 2 should be file th and Mentel Hy 7 is marked oths traumatic avent To Be C	19a. Informent's Name/Relationship (Type, Print) Donald W. Winters (Husband) 19b. Meiling Address (Street end Number of Street and Nu			
EZNE	Donald W. Winters (Husband) 3527 E. Fairmount 200. Method of Disposition 200. Plece of Disposition (Neme of		20c. Location - City o	
	1 General 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) Cametery, Cremetory or other place) Meadowridge Memorial Place Meadowridge Meadowridge Memorial Place Meadowridge Memorial Place Meado	Jan. 20	Elkridge,	
Baltim permit. Psg Department Important: I any Injury o	21. Strengturing Funeral Service Licensee 22. Name end Address of Fecility McCully-Polynia			20
	23a. Pert1. Enter the disease, or complications that capture the deeth. Do not enter the mode of dying, such as calculated a shock, or heart failure. List only one cause on each line.	rdiac or respiretory er	rest, Ma. 212	Approximete Intervel Between
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Physical dispersed of			ow Injury occurred	outy
ision thending F death. After tuner y the funer Ilcation:	The Neture 1 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No.			
or Atte effer des Directo lin by th	3 ☐ Suicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street end Number or I n, State)	Rurel Route Number,
Division of To the Hospital or Attending P within 24 hours efter death. To the Funeral Director: Affect completely filted in by the funeral Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end exemination end/or investigation, in my opinion, deeth one)			
the or the omple	end mepher steted. 29c. License number		29d. Date signed (Mor	nth, Dey, Year)
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State Registrar	1000 M			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lelia Webster 8:15 PM January 21 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Center Rosedele (av) Hunder 1 Year Hunder 24 Hrs. 8. Dete o Baltimore Hospital Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 1 M 2 F Months Deys Min. 219-12-8264 91 Yrs. Aug. 1907 Maryland Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1921 Grafton Shop Road 21050 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yea, Give Year or Dates: 1 ☐ Yes 2 ☐ XNo Specify: 3 Nidowed 4 Divorced White 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Eiementary/Secondary (0-12) Women's Apparrell 8th 0 Seamstress 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Elizabeth Kenley Walter M. Bishop 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stefa, Zip Coda) 1921 Grafton Shop Road Forest Hill, Md. 21050 Alfred G. Webster (Son) 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park1/25/99Elkridge, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225 lose 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia hours Dua to (or as a consequence of): Myocardia Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): tibrosis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

Examiner Physician/Medical Examiner attending physician and for use as the burial-tran 68760 Box P.O. 3 Records, þ Completed Division of Vital Be edicai Certification: To this After or Attending death. Director: sher 24 hours

Physician

/Medical

Examiner

Funeral

Director

28a-f show

8 Norms 23a Director

Funeral

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Completed

other traumatic event, the Massoni Examiner must be notified at

ifiled within 72 hours after it Hygiene.

Department of Health and Mental Hygi Important: If Item 27 Is marked other

any i

Physician /Medical

1 and 2 should be Health and Mental

25. Was case rafarred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Cartifier (Check only one)

State Registrar

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Borrello Dr Ivan

Drive Baltimore, Maryland 21237 9000 Franklin Square

29d. Date signed (Month, Dey, Year)

January 21,1999

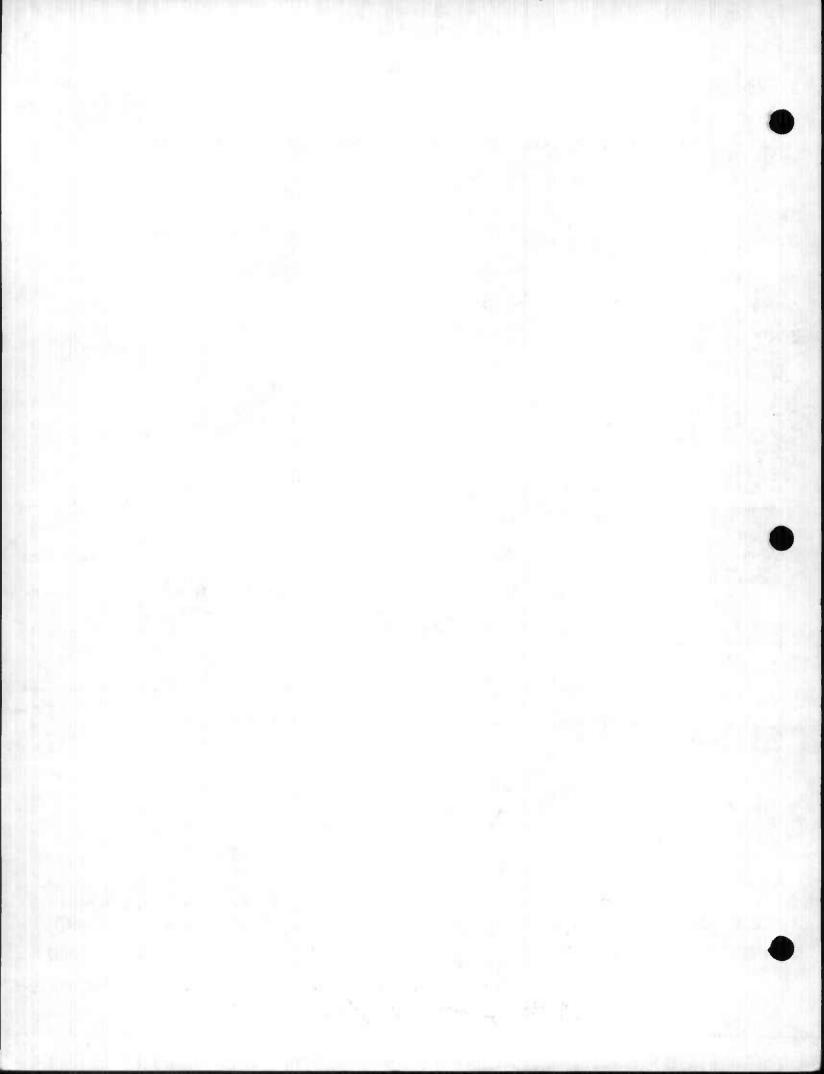
Day Year) 31. Date filed (Month

29b. Signeture find title of coult

32. Registrar's Signature

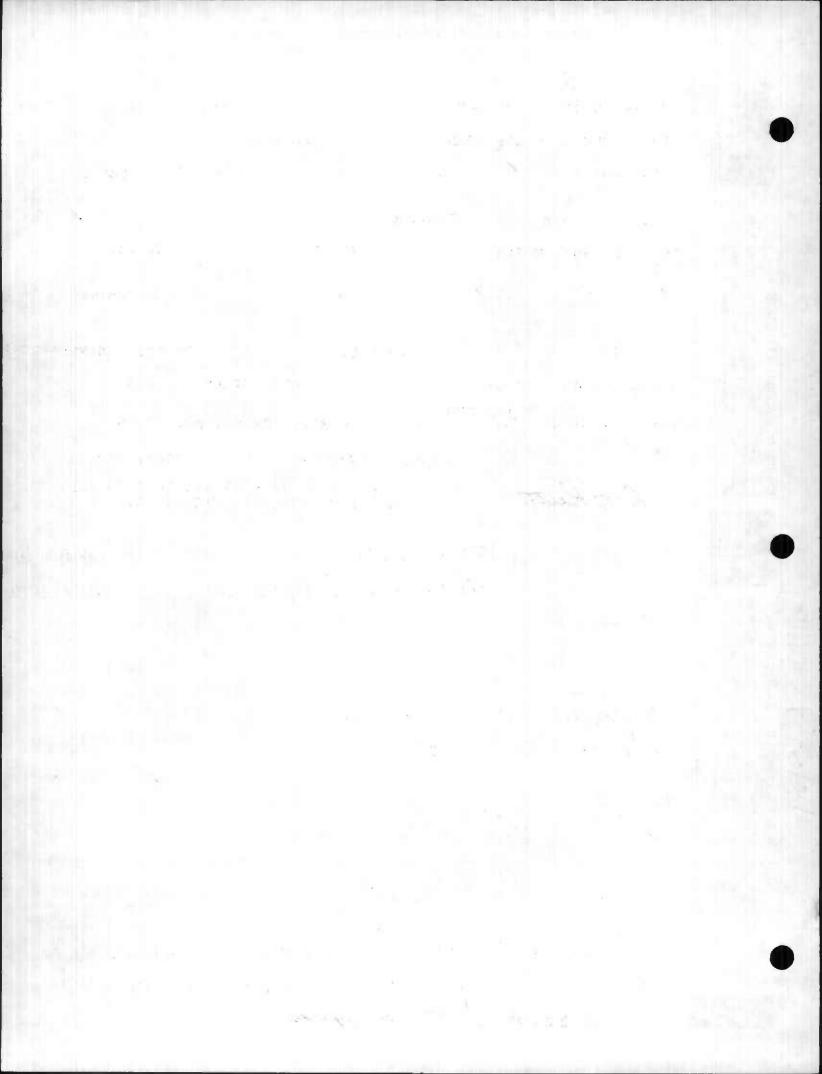
29c. License number

To the Hosp within 24 hos To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible

	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	eg. No.	3. Time of Death
ian cal	HELEN LUCILLE WILLEY	Month	2) 19	99 11:26 pm
er		Location of Death	4c. County o	
	UNION MEMORIAL HOSPITAL BALTIMO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs			N/A Rithologo (State or Foreign
	515-12-5179 1 M 2 F 87 Yrs. Months Days Hours Min		Year)	9. Birthplace (State or Foreign Country) KANSAS
	10a. Stata 10b. County 10c. City, Town or Location		1	10d. Inside City Limits
to	MD. N/A BALTIMORE			1XYes 2□No
Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wh	
al D	700 WEST 40th STREET 21211		U.S.	A •
by Funeral	11. Marital Status 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Maxican, Puan I Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Maxican, Puan I Yes, Give Year or Dates:	Specify Yas or No- to Rican, etc.)	Black	- Amarican Indian, Whita, atc. WHI'TE
2	3 □ Widowed 4 □ Divorced Year or Dates: 15. Decedant's Education 16a. Decedant's Usual Occupation		16b. Kind of Bus	iness/industry
Completed	(Specify only highast grade complated) (Give kind of work done during most of wo			
E O	Elementary/Secondary (0-12) College (1-4or 5+) INSPECTOR		CLOTHIN	G MANUFACTU
Bec	17. Fathar's Name (First, Middle, Last) 18. Mother's Na	me (First, Middla,	Maiden Sumame)
10	ALPHA REMGO WILLEY NOVA	VILLE	STEELE	Y
	19a. Informant's Name/Relationship (Type, Print) NEPHEW) 19b. Mailing Address (Street and Number or Fi	ural Routa Numbe	r, City or Town, S	tate, Zip Code)
	RALPH J. RIZZO, JR. 571 BROOK RD., TO			
	20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Nama of cemetery, crematory or other place)			ity or Town, State
	4 □ Donation 5 □ Other (Specify) HIGHLAND CEMETERY	1-29	IOLA,	KANSAS
	21. Signature of Funeral Service Ucensee 22. Name and Address of Facility HENRY W. JENE 4905 YORK ROAD			
	23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or haart failura. List only ona causa on aach lina.	c or respiratory arr	est,	Approximate Interval Batween
	Immediata Cause (Final Photographical			Onset and Death
	rasulting in death)			CIRCITIONS
ner	Due to (or as a consequence of):	aja		and man
Examiner	Sequentially list conditions, Due to (or as a consequence of):	9/100		0.7017017
EX	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events Due to (or as a consequence of):			1
dicai	Cause (Disease of Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of):			
w				
lan	Vi and the second secon			
Physiclan/M	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f.	23b. Did to		ribute to the cause of death
	congestive start failure	1 D Y	ee 2□ No	3 ☐ Probably 4 ☑ Onknow
Completed by	Afrial Fibrillation	24a. Was a perfor	in autopsy med?	24b. Were autopsy findings available prior to completion of cause of daath?
E C		1 🗆 Y	es 200No	1 □ Yes 2 □NO
BeC	25. Was case referred to medical 26. Place of Da	ath (Check only or		
0	axaminar? Hospital: Other:	Home 5□ Rasid		(Specify)
atlon: T	27. Mannar of Daath 1	_	ow injury occurre	
Certification:	3 ☐ Sulcide 4 ☐ Homicida 6 ☐ Could not be determined 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		r or Rural Routa Number,
edicai (29a. Carifiar (Check only one) 11 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and the place 2 Medical Examiner: On the basis of examiner: On the basi			
M	29b. Signature and the of certifier 29c. License number		9d. Data signad	(Month, Day, Year)
	ATOUR PRO ATOUR SCHILL	7	Tan	21, 1999
			1001	111111
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1
	30. Name and address of person who completed cause of death (Hem 23a) (Type, Print) Letita Hazel Union Memorial Hospita	J Bo	Utimor	e, md.



Certificate of Death Item: 31per V,R 1/26/99 reb 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Month **Physician** IANUARY Jewell Scott Walker /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ACOUNI 1 Under 24 Hrs. OR 8. Dete of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 M 20 F Yrs. 20,1932 Director 223-38-1357 66 Sept. Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location ehow Director 28e-f MD Anne Arundel Pasadena 10a Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23s or 312 Bar Harbor 21122 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Meritel Status Black, White, etc. 1 Yes 20 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 200No Specify: p 3℃Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene important: If item 27 is marked other that any lijury or other traumatic event, the boose. Homemaker Own Home 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Elsie Corner Sidney L. Scott 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8579 A Bay Rd., Pasadena, MD 21122 Julie S. Kerr, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Cemetery 1/14/99 Fredericksburg, VA 22. Name and Address of Facility Mullins & Thompson Funeral Serv. City Cemetery 21. Signeture of Funeral Service Licenses 1621 Jefferson Davis Hwy. Fredericksburg, VA 22401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

Examiner

Physician/Medical p Completed Be Certification: To

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? 27. Menner of Death

physician and the buriel-transit 080 signed by the this After

that the deeth certificate be executed Box 68760 P.O. Records, Division of Vitai or Attending Physician: death. hours after deal nerel Director: within 24 hours aft To the Funeral DI completely filled in

Hospital

To the

DHMH 16 Rev 6/95

State Registrar

Medical

AWRENCE 31. Dete filed (Morfth, Dey, Year)

29b. Signeture end title of certifier

1 Yes 2 No

Natural 2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homicide

5 Pending investigation

6 Could not be determined

28e. Date of Injury (Month, Day Year)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rurel Route Number, City or Town, State)

23b. Did tobacco use contribute to the cause of death?

1 | Yes 2 | No

2 No

24a. Was an autopsy performed?

28d. Describe how injury occurred

Other: 4 Nursing Homa 5 Residence 6 Other (Specify)

8:10 am

10d. Inside City Limits

Approximete Interval Between Onset and Death

mouth

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

MO

1 ☐ Yes 2 No

SUITE S.

26. Place of Death (Check only one)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) CHIN 5.

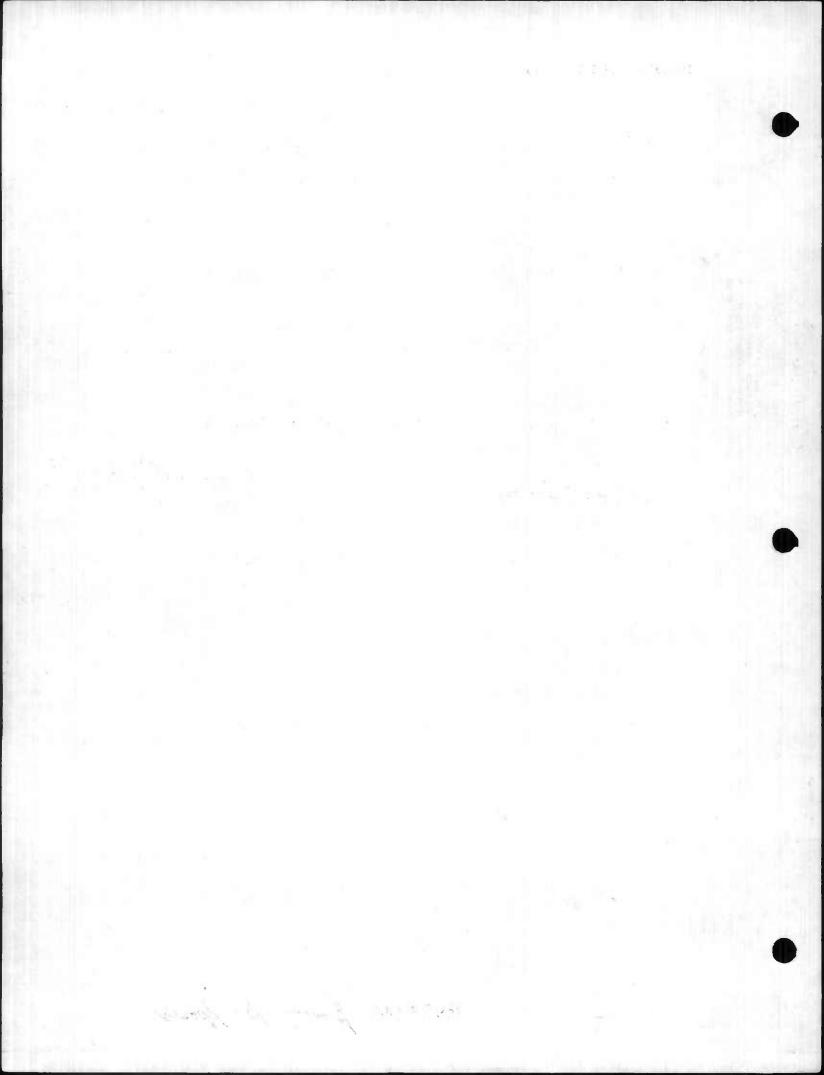
Inpatient 2 □ ER/Outpatient 3 □ DOA

28e. Pleca of Injury - At home, term, street, fectory, office building, etc. (Specify)

28b. Time of Injury

Due to (or as e consequence of):

Due to (or as a consequence of):



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Physician YOUNGER 8:00 A.M. PHYLLIS 21, 1999 4c. County of Deeth 1999 JANUARY /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death/ Examiner FRANKI'N SQUARE HOSPIAL CE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Rosed/ If Under 24 Hrs. CenTeR BAITIMORE Ale 8. Data of Birth (Month, Day, Year) SEPT 28 1951 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** Days 1□M 204 47 181-50-0460 MARYLAND Director Usual Basidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f ahow must be notified at 1 Yas 2 No Director MARYLAND BALTIMORE CO ESSEX 10a. Street and Number 10f. Zin Code 10a. Citizen of What Country? U.S.A. 1313 MAPLE AVENUE 21221 Funeral Was Decedent Ever in U,S. Armed Forces? □ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 1 Nevar Married XX Married 1 ☐ Yes 20XNo Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) College (1-4or 5+) NUFSE KIMPERLY QUALITY CARE 12th grade 2vrs 17. Fathar's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be nent of Health end Mentel HERMAN PHILLIPS UNA MAE ROSEPOROUGH 196Uh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) Important: if itam 27 is any injury or other tra once. 1313 Maple Avenue, Baltimore, Maryland 21221 Ronald Younger/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata >XXBurial 2 ☐ Cramation 3 ☐ Removal from State 1-28-99 COCKEYSVILLE, MARYLAND Department DULANEY VALLEY 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Nama and Addrass of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W MORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immediete Ceuse (Final disease or condition rasulting in death) /Medical · MYOCARDIAL INFARCTION Examiner Examiner STEMIC Sequantially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a cor NEPHR Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were autopsy findings available prior to complation of causa of death? STEROID DEPENDANCY 24a. Was en eutopsy 1 Yas 21 No 1 Yas

Vitai of

or Attending Physician: After Division death. after death 24 hours a Hospital

Be

Certification: To

Medical

25. Was casa rafarred to medical axaminar?

31. Data filed (Month, Day, Year)

JAN 26 1999

1 Yas 2A No

27. Mennar of Death

1 Natural

2 Accident

3 Suicida

29a. Cartifier

4 Homicida

within 2 To the \$ 0

State Registrar

5 Pending

invastigation

6 Could not be

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28b. Tima of

29c. License number

1 Yas 2 No

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mennar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

26. Place of Deeth (Check only one)

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

28d. Describe how injury occurred

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

28e. Data of Injury (Month, Day Year)

SIOO HARFORD ROAD BALTIMORE, MAR

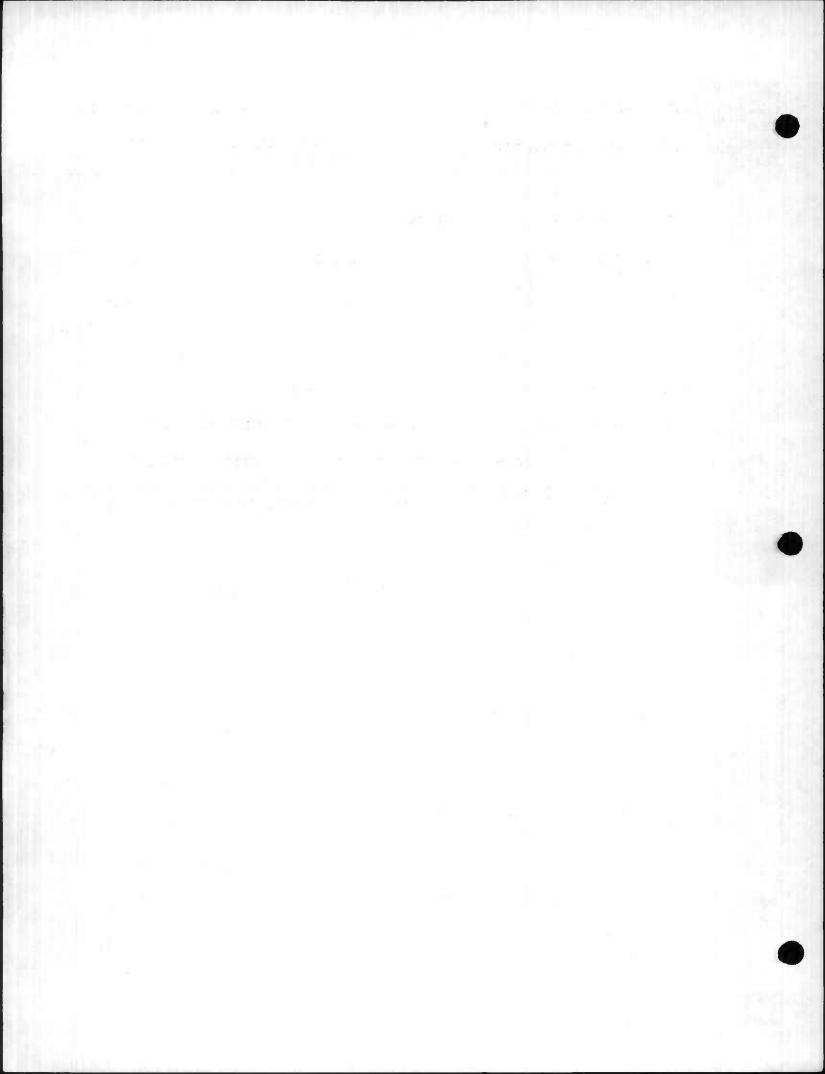
DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Physician Yeer PHILIP WILLIAM YUNKER JANUARY 18, 1999 1601 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** HAVRE DE GRACE HARFORD HARFORD MEMORIAL HOSPITAL
5. Sociel Security Number 6. Sex 7 7. Age (In yrs. lest birthday) If Under 24 Hrs. Birthpiece (State or Foreign Country) **Funeral** 8. Dete of Birth (Month, Dey, Year) 1 M 2□ F Months Deys Hours Min 64 Yrs. Director 389-34-2919 JULY 11, 1934 WISCONSIN Usuel Residence of Decedent death with the Maryland 10a. State r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No HARFORD MD ABERDEEN 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 842 LYNN LEE DRIVE 21001 Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after Never Married 2☐ Married 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) PHYSICIST US ARMY 12 5+ 7 is marked other traumatic event, altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme, Be Pages 1 and 2 should be nent of Haaith end Mental HARVEY YUNKER ROSE FOSTER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Haalth e 5728 W. MICHIGAN ST. WAUWATOSA, WI 53213 ANN GRIFFITH/SISTER other 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete ŏ 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or 4 □ Donetion 5 ☑ Other (Specify) ENTOMBMENT CATHOLIC CEMETERY 1/23/99 LACROSSE, WI 21. Signature of Funerel Servica Licensee 22. Name end Address of Fecility STERLING-ASHTON-SCHWAB FUNERAL HOME, INC. 736 EDMONDSON AVE. CATONSVILLE, MD 21228 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete tntervet Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificate be evecuted Sequentietly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Last Due to (or es e consequenca of) P.O. Box 68760, physician use as the Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. detached 23b. Did tobacco use contribute to the cause of death? signed by 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Records, þ 8 page 2 should 24b. Were autopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? cartificate has 1 Yes 2 No of Vital Physician: Be 25. Was case referred to medicat 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 300 Inpatient 2 ER/Outpatient 3 DOA s after dea...ral Director: After a...rby the funeral dir 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Division Attending Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 0 To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. Medical 29e. Certifier completely 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end address of person ited cause of deeth (Item 23e) (Type, Print) MOND OKION 31. Dete filed (Month 32. Registrar's Signeture State 26 1999

DHMH 16 Rev 6/95

Registrar



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DHMH 16 Rev 6/95

		Decedent's Neme (First, Middle, Las	State of Marylar		rtment of I			Reg. No.	018	ma of Deeth
	Physician /Medical	Jerome Charles 2 4e Facility Neme (If not Institution, give	Zavodny Sr.	-		4b. City, Town, or Lo	Januar Januar	Dey 24, 19	Yeer 999 3:	00 AM
	Examiner Funeral Director	VA MHCS FORT HOWAI 5. Social Security Number 6. So	RD DIVISION	. lest birthdey) Yrs.	If Under 1 Yeer Months Deys	Fort H If Under 24 Hrs. Hours Min.	oward 8. Date of Birt	Ва	altimore	
pue	wo wo	Usuel Residence of Decedent 10e. State 10b. County	10c. C	ity, Town or Lo	cation					ide City Limits
Mary	and short	Maryland I	N/A	Ba1	timore				1.00	Yes 2 □ No
ith the	or 28 be not	10e. Street end Number			10f. Zip Code			10g. Citizen of V		
eath w	eral	3515 Juneway	12. Wes Decedent Ever in U	19 13 1	1	1213 Hispanic Origin? (Sp	ecify Ves or No	7	S. A. e - American Indi	en.
5-0020 72 hours after death with the Maryland	Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show important: If Item 27 is marked other than the notified at once. To Be Completed by Funeral Director	1 Never Married 2 Married 3 🗹 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:1943-	1	f Yes, specify Cub	en, Mexican, Puerto	Rican, etc.)		k, White, etc.	
Maryland 21215-0020	Medical in Pieted	15. Decedent's Ed (Specify only highest gra-	ucation	16e. Deced	lent's Usual Occu kind of work done OO NOT use retire	during most of work	rking 16b. Kind of Bus		siness/Industry	
d 2121	Hygiene. Wher than ent, the M	12th Grade		St	eel Work	T			Manufact	urer
and	ed outh	17. Fether's Name (First, Middle, Last)				18. Mother's Nem		Meiden Sumen	ie)	
Should	and Mentel Is is marked of aumatic eve To Be	Antoine Zavodny 19a. Informent's Name/Reletionship (7)	Type, Print)	19b. Meilin	ng Address (Stree	Anna D terid Number or Rui	robnik	er, City or Town,	Stete, Zip Code)	
, M	e tra	Jerome C. Zavodny		211	Northvie	w Road, B	el Air,	Maryla	nd 21015	
ore	or oth	20a. Method of Disposition 1 Ø Burial 2 ☐ Cremetion 3 ☐	20b. Removel from State	Plece of Dispo- cemetery, cren	sition (Neme of netory or other ple	oce)	Dete	20c. Location -	City or Town, St	ate
Baltimore, semit. Peges 1 e Department of Hee mportant: If Item any Injury or othe	ntment:	4 Donetion 5 Other (Specify) Ga		of Faith	ess of Fecility Funeral		-	re, Mary	land
B B	pemii. Pepes 1 and 2 Deperment of Health a Important: if item 27 is any Injury or other tra pace.	21. Signature of Funerel Service Licen Buin a U	yland 21	land 21213						
	nysician	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	plicetions thet caused the dee one ceuse on each line.	th. Do not ent	er the mode of dy	ing, such es cerdiec	or respiretory e	rrest,	Interv Onse	el Between t end Deeth
	Medical xaminer	Immediate Cause (Finel disease or condition resulting in deeth)	e Laryngeal C	arcinom					29	Yrs.
pet	o And Sal-transit		b. Chronic Obs			ary Disea	se		Yrs	5 .
O,	hysician kod the burial-trad	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Old Myocard	or es e consequial Inf					Yrs	3.
.O. Box 68760, the death certificate be executed.	- m	Ceuse (Disease or Injury that initiated events resulting in death) Lest	C	or es e conseq						
Box auth cert	for use		d							
م يو	7 6	Pert II. Other significant conditions of	ontributing to death but not re	sulting In the ur	nderlying cause gi	ven in Pert I.		tobacco use co Yss 2□ No	ntribute to the ca 3 ☐ Probably	ause of death?
Records,	shoul etec							en eutopsy med?	24b. Were aut evalleble completic of deeth?	prior to on of cause
	page 2						10	Yes 20 No	1 ☐ Yes	2 No
Vital	certificete rector, pag	25. Wes case referred to medical examiner?	Massital		100	26. Plece of Deel	th (Check only o	one)		
Phys Of	T T	1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending 2 Accident Investigation	28e. Date of Injury (Month, Dey Year)	28b. Time of tnjury	28c. tnju			5 Residence 6 Other (Specify) Describe how injury occurred		
Division	rs after death. al Director: After t ted in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined						per or Rurei Rout	ər or Rurei Route Number,	
e Hospita	within 24 hours after To the Funeral Dire completely filled in b Medical Certi		ysician: To the best of my known and menner stated.							suse(s)
Tot	To the common	29b. Signeture end title of certifier	- 0	0	29c. Licen			29d. Dete signe	d (Month, Dey, Y	'ear)
	1-	Augustin	Chyu. m			-18298	2	1/24	199	
	0	30. Neme and eddress of person who				+ Howard	MD 210	52		
	State	Augustin Chyu, MD 31. Dete filed (Month, Day, Yeer)	32. Registrer's Sign				END ALV.	- 44		
	Registrar	JAN 26 19	399 Sener	9.	Loon	1/2/				

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nerock or refer or a statement the beauty of the property of

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JANUARY 12, HELEN 9:30 PM MARIE 1999 AYRES /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner RANDALLSTOWN BALTIMORE ROBOSSON COURT NURSING CENTER If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Months Days 1 M XXF Yrs. 215-58-9041 APRIL 22,1903 Director 95 BALTIMORE Usuel Residence of Decedent with the Maryland r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo RANDALLSTOWN MARYLAND BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be r 4511 ROBOSSON ROAD 21133 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours aftar deeth v Department of Health and Mentel Hygiena. Important: if item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must bings. Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumeme) Be JOHN WARD MARY (UNKNOWN) 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ROBERT GOERING 9100 VEGA COURT, RANDALLSTOWN, MD. 21133 (NEPHEW) 20b. Placa of Disposition (Neme of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XIXI Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LAKEVIEW MEMORIAL PARK 1/16/99 SYKESVILLE, MD. 22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 ant. Entitl the userse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical malnutnition **Examiner** Due to (or as a consequenca of): Examiner Demuntice attending physician and for use as the burial-transit that the daath certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequance of) P.O. Box 68760, Dua to (or as a consequence of): Physician/Medical ALC: Dunts resulting in deeth) Lest 88 ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown D. C. Bukus Mulle Lus Division of Vital Records. þ 8 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed page 2 SBC certificate 1 Yes 2 No director, 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 After this funeral 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician: after death. Director: Aft 3 Hospital 24 hours within 24 hor To the Fune completaly fi the 2

> State Registrar

Medicai

Dey, Year) 32. Registrar's Signature Allen 31. Date filed (Month, Dey, Year) JAN 1 5 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and titla of certified



28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

5310 CID COURT

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated.

Madical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

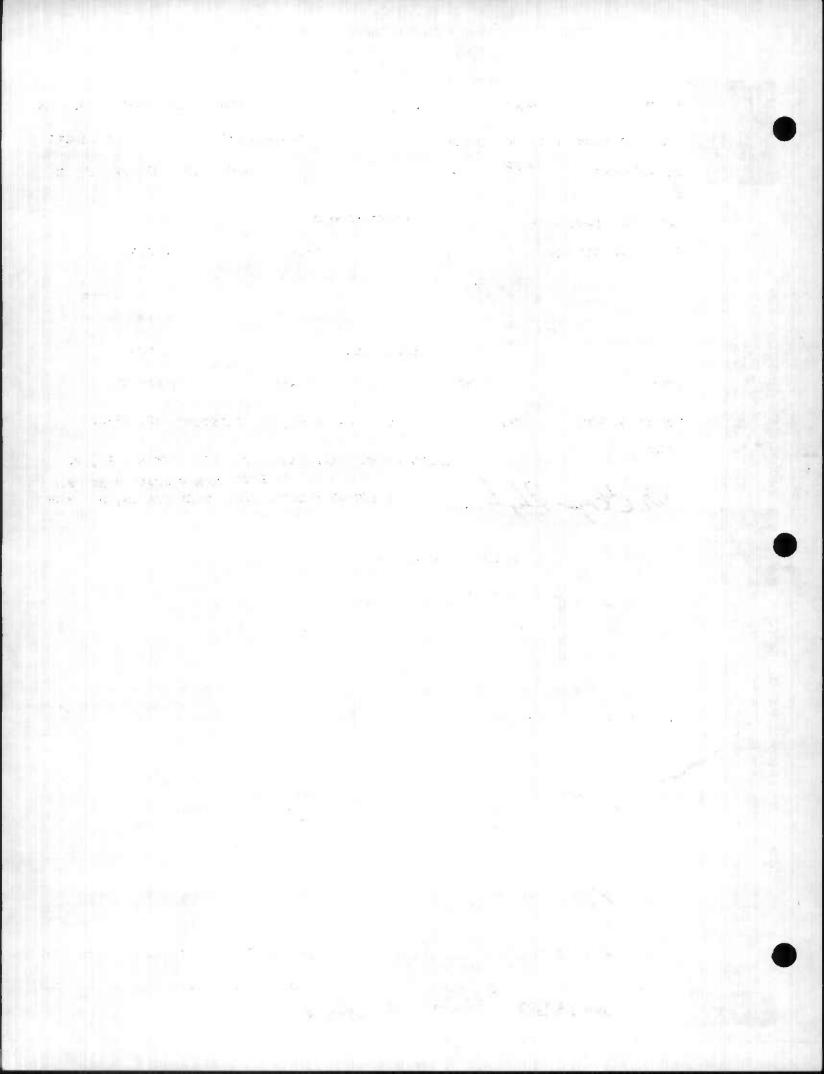
29c. License number

024085

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

January 14 1997



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State of Maryland / Department	of Health and Mental Hygiene	99	01	8	1

JOANNA BEANS	ITEN	MS: #23 PART I, 27 PER 1. Decedent's Name (First, Middle, Li	MEO G767 1-	-			Death	2. Date of D	Reg. No.		3. Time of Death	
Physi /Me	ician dical	Joanna Adele Be						Month JANUAR	Dey	Yeer	2:20P.M.	
Exam		4a Facility Name (If not institution, gi	ve street and numbe	r)			4b. City, Town, or L	ocation of Dea	th 4c. County			
		ANNE ARUNDEL MED					ANNAPOLIS		ANNE	ARUNDE	EL	
Funera Directo		215 53 0105	Sex 7. / 1□ M 2⊠ F	Age (In yrs. I		Months Days 5 12		(Month, D	irth Nay, Year) .5, 1998	9. Birthplac Country Mary 1.	e (State or Foreign and	
Du B		Usuel Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation		_		104	. Inside City Limits	
daryt aho	6	Maryland Anne Ar	un de 1								1 ☐ Yes 2 🖔 No	
170 the	Director	10e. Street and Number	dirdel	Riv	a	10f. Zip Code			10g. Citizen of	Whet Country	7	
3a or		3092 Sussex Place				2114	0		United :			
deeth	Funeral	11. Marital Status	12. Wes Deceder	t Ever in U,	S. 13. W	as Decedent of I	Hispanic Origin? (S	pecify Yes or N	o- 14. Rad	ce - American		
within 72 hours after deeth with the Manyland ane. Then "natural", or frems 23a or 28a-f ahow he Medical Essariose mass be notified at	þ	1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Detes] No		Yes, specify Cub	Specify:	o Hican, etc.)		ck, White, etc y: Blacl		
2 hou	3	15. Decedent's E				ent's Usuel Occup			16b. Kind of B	usiness/Indus	stry	
poemit. Department of Health and Should be lifed within 72 hours at Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or any injury or other treumatic avent, as Medical Essent	Completed	(Specify only highest gr Elementery/Secondary (0-12)	College (1-4o	r 5+)	(Give I lite. D	and of work done O NOT use retire	during most of world)	king				
il Hygir other	Be C	17. Father's Neme (First, Middle, Las)				18. Mother's Nen	ne (First, Middle	e, Meiden Sumar	n <i>e)</i>		
should be nd Mentel marked o	ToB	Robert E. Beans					Adele L	. Thoms				
2 sho	-	19e. Informent's Neme/Reletionship	(Type, Print)		19b. Meiling	Address (Street	t and Number or Ru	ral Route Numi	ber, City or Town	Stete, Zip C	ode)	
end ealth		Adele L. Beans	(Mother)		3092 5	ussex P	lace Riv	a, MD.				
permit. Pages 1 are Department of Hear Important: If Item in Jury or other		20a. Method of Disposition 1 X Burial 2 Cremetion 3 D	Removel from Stat	00	ace of Dispos emetery, crem	ition (Name of atory or other pla	ice)	Dete	20c. Location	- City or Towr	, Stete	
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pemit. Departr Importu eny inj	Buc	21. Signeture of Funeral Service Lice	1/20	a		Name end Addre	Join of Glouce				Home, Inc	
Physician /Medica Examine	il er	shock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)		INFANT	DEATH S						tervel Between nset end Death	
uted Unsit	Examiner		b	Due to for		10000 of				- 1		
cate be axecuted physicien and sthe burial-transit	I Exa	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		io) oi eud	es e consequ	ierica or).				 		
	Medical	that initiated events resulting in death) Last		Due to (or	es a consequ	ence of):						
esth cert for use	lan		d									
that the desth certified by the attending detached for use a	Physician/M	Pert It. Other significant conditions of	contributing to death	but not resu	Iting in the un	derlying cause gi	ven in Part I.	23b. Dic	i tobacco use co	entribute to the	ne cause of death?	
requires that the seen signed by the hould be detached	by Ph							1	Yes 2 No	3 Probel	bly 4 Unknown	
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delan: The certificate rector, pag	Be C	25. Wes case referred to medicat					26. Place of Dee	eth (Check only	1			
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ding Ph After th funeral		27. Manner of Death 1 ☑Neturel 5 ☐ Pending	28a. Dete of In (Month, D	jury ay Year)	28b. Time of tnjury	28c. Inju Wo	ry at	28d. Describe	how injury occu	rred		
Attender octor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be	Accident investigation Suicide 6 Could not be determined the control of the contr						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Hospital 24 hours Funeral stely filled	edical C		nysician: To the bes niner: On the basis and manners	of examineti								
To the Within To the comple	2	29b. Signature and title of certifier	/ ,			29c. Licens	se number		29d. Dete signe	ed (Month, Da	y, Year)	
, , , , ,		Marol	orland)		0.0	M.E.		JANUARY	13,19	99	
		30. Name and address of person who	completed cause of	death (Item	23a) (Type, F		n Street,	, Baltir	nore, Ma	ryland	21201	
S	tate	31. Dete filed (Month, Day, Year)		trer's Signet	ure	1-	1,					

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 AMEND# 5 1-14-99 cmh AACO HEALTH DEPT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day JANUARY 7, 1999

Of Death 4c. County of Deeth **Physician** PEARLY W. CARR 2:40 PM - /Medical 4a Facility Neme (If not institution, giva street and number) 4h. City. Town, or Location of Death Examiner AGNES HOSPITAL BALTIMORE 5 Social Security Number 214-05-0688 214005-0688 if Under 1 Year 7. Age (In yrs. last birthday) 6 Sax 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 180 M 2□ F Months Days Yrs. 85 Director MARCH 8 1913 MARYLAND Usual Residence of Deceden with the Merylend 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1729 ST. MARGARETS RD. 21401 US Funeral deeth 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ Xlo If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, atc.) 14. Race - American Indian. Biack, Whita, etc. 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🖫 No Specify: Specify:BLACK þ 3/□Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Hygiene. Elementary/Secondary (0-12) ADMIRAL FARRAGUT College (1-4or 5+) 7th PAINTER **APARTMENTS** 18. Mother's Name (First, Middla, Maiden Sumema) 17. Father's Name (First, Middla, Last) . Pages 1 end 2 should be file ment of Heelth end Mentel Hy lant: If Item 27 is marked oth Be DAVID CARR MURRAY ELLA 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code)
1729 ST. MARGARETS RD. ANNAPOLIS, MD. 21401 19a. Informent's Neme/Reletionship (Type, Print) ALVINA SPRIGGS (SISTER) other t 20a. Method of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or injury or ASBURY BROADNECK CEME. 1/12/99 ST. MARGARETS MD. 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disaasa, or complications that ceusad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. eesa Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Asperation Preumonia nours Examiner Due to (or as a consequence of) Examiner Failure physicien end sthe buriel-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 80 USB signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 hes 1 Yes 2 € 10 1 ☐ Yes 2 ☐ No certificate director, 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28a. Dete of Injury (Month, Dev Year) 28c. Injury at Work? Naturat Accident 5 Pending efter death. Director: Aft 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Numbar or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homicide Hospital or 24 hours e Sertifying Phyelclan: To the best of my knowledge, death occurred at the time, dete end ptace, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ptace, and due to the cause(s) end manner stated. 29a, Certifier To the Hosp within 24 hou To the Funel completely fi edical 29d. Date signed (Month, Day, Year) 29c. Licansa number 29b. Signature and title of certifier

Physician

Sant Agnes Emergency

900 Caton

AVENUE

21220

npleted cause of death (item 23a) (Type, Print)

32/ Registrar's Signature

State Registrar 31. Deta filed (Month, Dey, Year)

JAN 1 4 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1999 0419 JOSEPHF. COLLINS Januar /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sep 6, 1928 BALTIMORE BALTIMORE CITY UNIVERSITY OF MARYLAND MEDICAL CENTER 9. Birthplaca (State or Foreign Country) New York 6. Sex 1 M 2 F **Funeral** 092-20-8524 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at Worcester 1 Yes 2 No Ocean City Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13313 Peach Tree Road 21842 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. e flied within 72 hours after d il Hygiena. other than "natural", or Item 1 Ayes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WWII p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cement Regional Sales Manager permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If item 27 Is marked oths any Injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Joseph Collins Lillian Ouinn 19e. Informent'a Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Janet R. Collins / wife 13313 Peach Tree Road, Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 11 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from State Baltimore, MD Metro Crematory 4 Donation 5 Other (Specify) 1999 Signature of Funeral Service Lic 22 Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. **Physician** /Medicar Impedieta Cause (Final bleeding Gastrointestina disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner 38 days Sepsis physician and the budal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): days duoderal ulcer hemorrhage Box 68760 Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery disease Respiratory Failure Records, þ 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Be Completed Renal Failure Diabetes Peptic Ulcer disease Peripheral Vasular disease 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital or Attanding Physician: 25. Wes case rafarred to medical examiner?

1 Yes 2 No 26. Placa of Deeth (Check only one) Hospital: 192 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d, Describe how injury occurred 28b. Time of 1 Naturel 5 Pending deeth. 1 Yes 2 No To the Hospital or Attandi within 24 hours after deeth. To the Funeral Director: A complately filled in by the f investigation 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO AV417645E9222 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Ray 6/95

State

Registrar

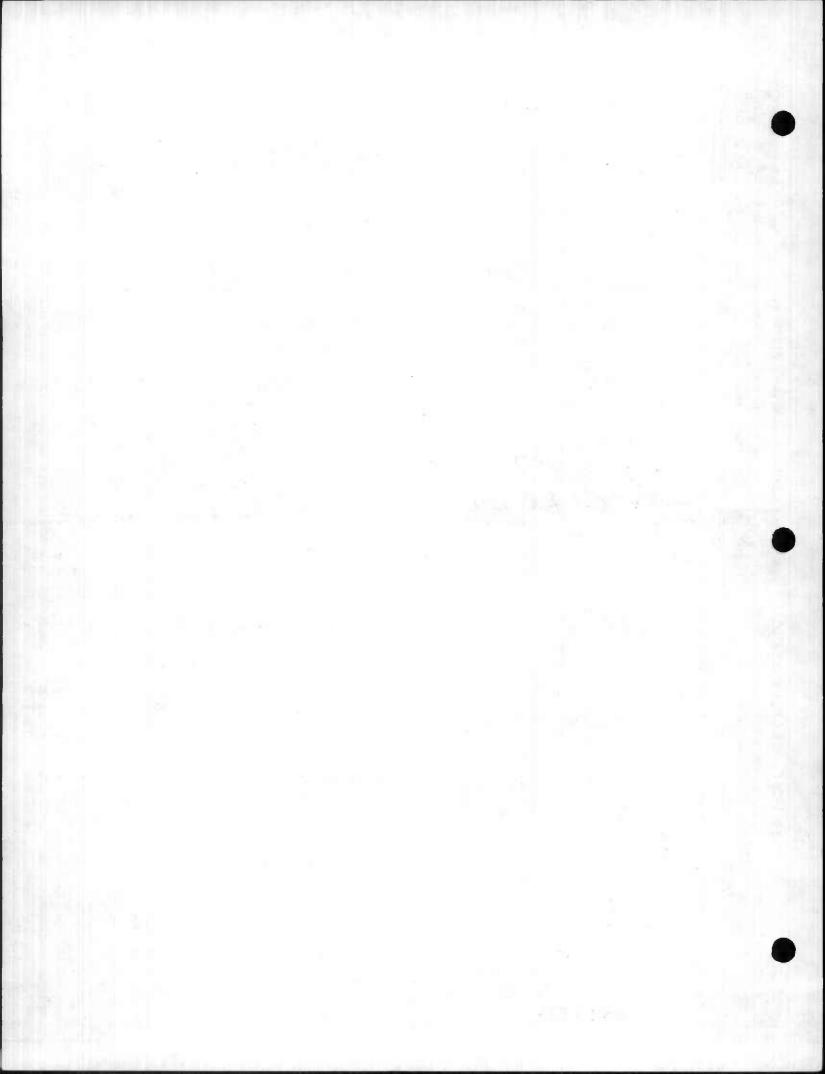
MICHARL EBRIGHT, MD

JAN 1 2 1999

31. Dale filed (Month, Day, Year)

, 22 S. GREWR ST.

32. Degistrar's Signeture



			Please			d / Dep		k. Assure I Health and Death	Mental Hy	64	ble.	01817
		1. Decedent's Name	e (First, Middle, La	st)			100		2. Dete of De			3. Time of Death
	ysician	ANNA	ELI	ZABETH		GRAE	FE		JANUAR!	Day Y 12, 19	Year	6:45 PM
VA.	fedical aminer	4a Facility Name (fi	f not Institution, giv	re street end num	iber)			4b. City, Town, or		1	-	
LA	attitici	MARINER	HEALTH O	F NORTH	ARUNDEI			GLEN F	BURNIE	ANNE	ARIIN	IDEL
Fun	eral	5. Social Security N	umber 6. S	Sex 7	7. Age (In yrs. I		If Under 1 Yee	If Under 24 Hrs	s. 8 Date of Bir	th	9. Birth	place (Stete or Foreign
Direc		156-18-33 Usual Residence of	321	I□M 2ÀF	93	Yrs.	Months Deys	s Hours Min	JAN. 1	1,1906		NSYLVANIA
rylan	5	10a. State	10b. County		10c. City	, Town or L						10d. Inside City Limits
Me -	cto	MARYLAND	ANNE A	RUNDEL		GLEN	BURNIE					1 ☐ Yes 2 No
1215-0020 within 72 hours effer death with the Meryland ane. than "natural", or items 23s or 28s-f show	al Director	10e. Street and Nun 817 CEDAR		DRIVE			10f. Zlp Code	21061		10g. Citizen of U.S.		intry?
deat	Funeral	11. Marital Status		12. Was Deced		S. 13.	Was Decedent of	Hispanic Origin? (Specify Yes or No			ican Indian,
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21215-0020 d within 72 hours efter death w giene. r than "natural", or Nems 23s.	Completed	/Sneo	15. Decedent's Ed	ducation		16a. Dece	edent's Usual Occi	upation	ndrina	16b. Kind of 8	usiness/li	ndustry
12 E	e de	Elementary/Seco		College (1-	4or 5+)	life.	DO NOT use ratir	e during most of wo red)	Ji King			
D D b	Con	6				BUTC	HER			FOOD	FAI	R
and 2 be filed the Hygin	Be Comp	17. Father's Name	(First, Middle, Last,)				18. Mother's Na	ame (First, Middla	, Maiden Sumei	ne)	
Maryland d 2 should be file th end Mentel H;	10	JOHN			U.	PTON		MARY			(UI	NKNOWN)
Aar 2 sho end is me	traumatic	19a. Informant's Na	ame/Relationship (Type, Print)		19b. Mail	ing Addrass (Street	et end Number or F	Rural Route Numb	er, City or Town	, Stata, Zi	ip Code)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** 820 CLARA L.GUYER 1999 AM JAN /Medical 4a. Facility Nama (If not institution, giva street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western Maryland Hosp. Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Days Hours Min. (Month, Day, Year)
Jan. 11, 1923 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 1 M- 20 F 169-38-6187 Yrs. Director Pa. Usuai Residence of Decedent 10c. City, Town or Location 12675 Mercersburg Rd Greencastle, Pa. 17225 10a. State 10b. County 28a-f show 10d. Inside City Limits Examiner must be notified Director Franklin 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 12675 Mercersburg Rd. 17225 23a USA Funeral death 12. Was Decedent Ever In U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ltems ; 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. hours after 1 Naver Married 2 Married altimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify þ 3X Widowed 4 □ Divorced Whi te Be Completed 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 tonent of Health and Mental Hygiene.
Int: If Item 27 is merked other than "natury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Daniel F. Barnhart 2 Mary Seville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) L. Gene Barhhart P.O.Box 597 Hustontown, Pa. 17229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c tocation City or Town State
Hamilton Twp
Franklin Co., Pa 20a. Method of Disposition 1 ♣ Burlal 2 □ Cramation 3 □ Removal from State Olivet permit. Page Department of Important: If any Injury or 1/22/99 4 ☐ Donation 5 ☐ Other (Specify) 1/22/99 Cem. 21. Signature of Funaral pervice Licensae Lininger-Fries 17 N. Park Ave. Mercersburg, Pa. 22. Name and Address of Facility Funeral Hom Ave. 17236 munger 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deeth **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical & PROBABLE ACUTE MYOCARDIAL INFARCTION HR Examiner Physician/Medical Examiner CORONARY ARTERY DISEASE requires that the death certificate be executed physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last 68760 Due to (or as a consequence of): 88 Box use P.O. Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? signed by 1 1 ☐ Yes 2 No 3 Probably 4 Unknown HYPERTENSION, DIABETES MELLETIUS, Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? ATRIAL FIBRILLATION, PERIPHERAL VASCULAR The law CONGESTIVE HEART 1 ☐ Yes 2 No O)SEASE, ANASARCA, FAILURE
25. Was case referred to medical examiner?

Hospital: 1 ☐ Yes 2 ☐ No Vital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No

27. Menner of Death

1 Natural 5 Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To of 28c. Injury at Work? 28d. Describe how Injury occurred After Division s after dean. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ HomicIde Hospital 24 hours Medical 29a. Cartifier Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. To the Hosp within 24 ho To the Fune completaly fi 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of centifier 29c. License number 29d. Date signed (Month, Day, Year) MD 034537 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 1500 PENNSLYVANIA AVE WESTERN MARYLAND HOSPITAL CENTER HAGERSTOWN, MD 21742

State Registrar 31. Data filad (Month JAN 2 7 1999 EED O O COM

32. Registar's Signeture

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			1,44	4b. City, Town, or	Location of Deat	4c. County	of Death	
		last hirthday)	Inder 1 Year	Arnold If Under 24 Hrs	R Date of Bir			State or Femine
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Usual Residence of Decedent	10				June 1	1950	IVEW	IOIK
10a. Stata 10b. County	10c. C	City, Town or Locatio	n				10d. In:	side City Limits
MD Anne	e Arundel	Arnold					1[Yas 2ÑNo
10e. Street and Number		10				_	What Country?	
789 Riverside Dr:	ive		2101	.2		USA		
11. Marital Status	12. Was Decedent Evar in Armed Forces?	U,S. 13. Was	Decedent of I	Hispanic Origin? (S	Specify Yes or No	- 14. Rac		lan,
1 Never Married 2 Married	1 Yes 2 No				, , , , , ,			۵.
	Year or Dates:							
15. Decedent's E (Specify only highest g	Education rade completed)	16a. Decedent's (Give kind	Usual Occu of work done	pation during-most of we	rking	16b. Kind of B	uainess/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)				1	Medi	cine	
17. Father's Name (First, Middle, Las		1			me /First. Middle	Maiden Suman	ne)	
	· · · · · · · · · · · · · · · · · · ·	19b. Mailing Ac	dress (Stree				State Zin Code)
20a. Method of Disposition								ate
1 ☐ Burial 2 XCramation 3 I	_Inemovariioni State							
/		-						
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100 CO.	Yallon	7 A A95 (GOV. R	itchie H	wy., Sev	erna Pa	rk, MD 2	21146
Immediate Cause (Final								ral Between f and Death
disease or condition resulting in death)	•							
				DTEDV				
Sequentially list conditions	D			INTERT -				
if any, leading to immediate cause. Enter Underlying		SEAT TO SEA WAS A SEA OF	-10-14/	126425				
that initiated events				MACHAEL				
America Coloresto Marine								
	d.							
Part II. Other significant conditions	contributing to death but not re	sulting in the under	ring cause gi	ven in Part I.	23b. Did	tobacco use co	intribute to the c	ause of death?
					10	Yes 2□ No	3 Probably	4ETUnknow
							availabie	prior to
	1 -1 1 2 3					/	of death	on or cause
					103	Yes 2 No	1 DYes	2 🗆 No
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25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 № Residence 6 ☐ Other (Specify)							
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	Lisa Ma 4a Facility Name (Ill not institution, g. 789 Riverside Dr 5. Social Security Number 078-44-6240 Usual Residence of Decedent 10a. Stata 10b. County MD Anne 10a. Street and Number 789 Riverside Dr 11. Marital Status 1 Never Married 2 Married 3 Widowed 1 Divorced 15. Decedent's Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las Anthony Cenzopr 19a. Informant's Name/Relationship Bryan L. Glorioso 20a. Method of Disposition 1 Burial 2 XCramation 3 (1) 4 Donatton 5 Other (Special Secondary (1) 15. Sequentially list conditions 1 Service Los 16. Part Enter Indestrying Cause (Disease or Condition resulting to duath) Sequentially list conditions 1 Sequentially list conditions	4a Facility Name (If not institution, give street and number) 789 Riverside Drive 5. Social Security Number	Lisa Marie Glorioso 4a Facility Name (If not institution, give street and number) 789 Riverside Drive 5. Social Security Number Of Security Number OT8-44-6240 108-44-6240 109-44-6240	Lisa Marie Glorioso 4a Facility Name (If not Institution, give street and number) 789 Riverside Drive 5. Social Security Number 078-44-6240 1	Lisa Marie Glorioso 4a Facility Name (If not institution, give street and number) 789 Riverside Drive 5. Social Security Number 078-44-6240 5. Social Security Number 10a. State 10b. County MD Anne Arundel 10c. City, Town or Location Arnold 10c. City, Town or Location Arnold 10c. Street and Number 789 Riverside Drive 11. Marital Status 1 New Farried 1	Lisa Marie Glorioso As Facility Name (If not institution, give street and number) 48 Facility Name (If not institution, give street and number) 49 Riverside Drive 5. Social Security Number 10 S. Social Security Number 10 March - 62 240 Lisa Marie Glorioso Anne Arundel Social Security Name (If not institution, give street and number) 48. City, Town, or Location of Death Anne Arundel 108. Social Security Name (If not institution, give street and number) 78. Age (in yrs. last birthday) 48. Yrs. 108. Social Security Name (If not institution) 108. Social Security Name 108. Social Security Name 109. County 48. Yrs. 100. City, Town or Location Arundel 109. Street and Number 78. Riverside Drive 100. City, Town or Location Arundel 100. Street and Number 101. Zp Code 21012 102. City, Town or Location Arundel 103. Street and Number 104. Street and Number 105. Specify 105. Code of Birth (Month, Buy, Year) Thirle 11, 1950 109. City Town or Location Arundel 109. Street and Number 100. Street and Number 100. Specify 100. City, Town or Location Arundel 100. Street and Number 100. Specify 100. City, Town or Location Arundel 100. Street and Number 100. Specify 100. City, Town or Location Arundel 100. City, Town or Location Arundel 100. Specify 100. City, Town or Location Arundel 10	Lisa Marie Glorioso Month Day Year January O5, 1999 1 January O5, 1999 January O5, 1999 January O78-44-6240 1 Maria Satur January Jan	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth Month 14, 1999 Frances Fleming Harstick January O6:15am 4e. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Dorchester General Hospital Cambridge Dorchester 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar 13,1921 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 1□ M XX F Mary Land 214-12-5899 Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Dorchester Maryland Cambridge 1 Yas XXXX 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4 Sunset Lane 21613 US 11 Marital Status Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 1 Yes YN No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: White 3 ☑ Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grade completed) 16a. Dacedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Restaurant Owner Food Service 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John A. Fleming Susie Bradlev 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sue H. Wyatt Daughter 320 Sunburst Highway Cambridge, Maryland 21613 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1) Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Memorial Park 1/16/99 Cambridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature unerel Service Licensee Thomas Funeral Home, P.A. my 700 Locust Street Cambridge, Maryland 21613 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, and or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Abdommal apric Aneurysm re End stage chrome obstructure lun Sequentially list conditions, if any, laading to Immediate causa. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 [] Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be executed anding physician a Box 68760, Records, P.O. Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

Physician

/Medical

Examiner

.Funeral

Director

Items 23s or 25s-f show

natural, or

Hygiene.

Department of Health and Mental Important: If Hem 27 is marked or any injury or other traumatic ev once.

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page 2 should Completed

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Certification: To

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Saltimore, Maryland 21215-0020

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Funeral

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25. Was case refarred to medical 1 Yes 2 No

11 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end manner stated. (Check only one)

29b. Signature and the of pedifier

29c. License number

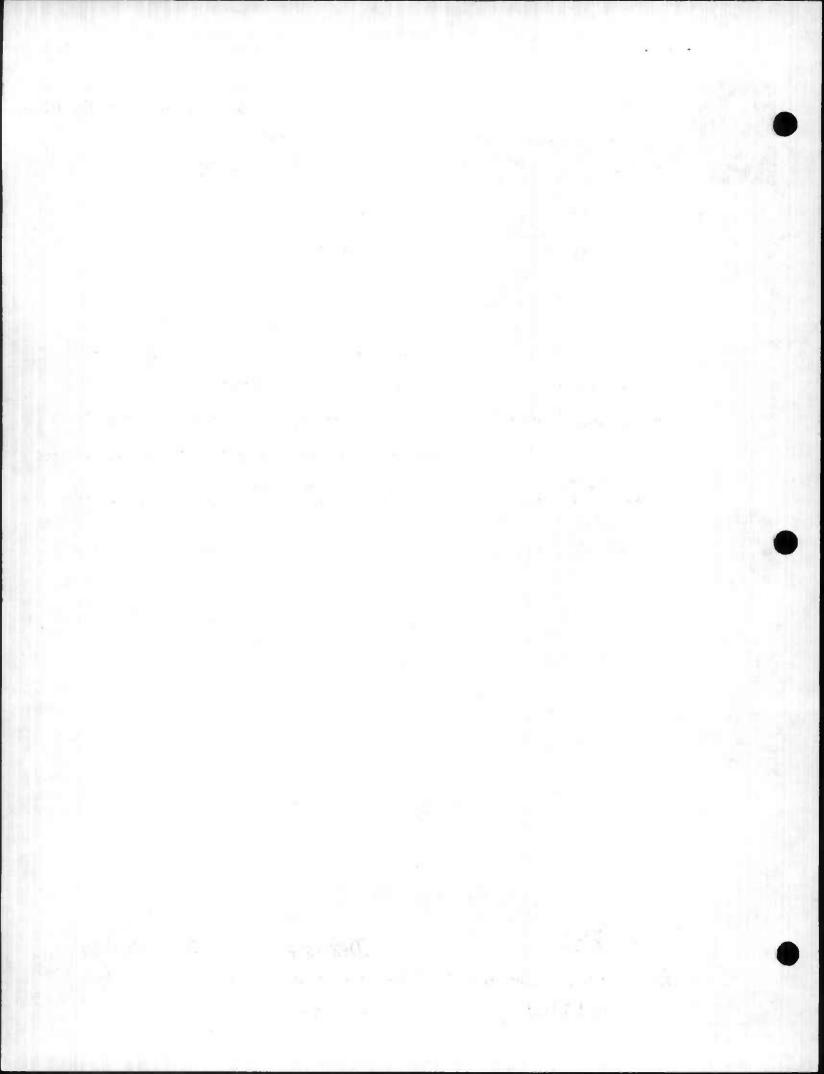
29d. Date signed (Month, Day, Year)

Jan. 14, 1999 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) sieie Cambridge mo Nawa 3 105

1) 32. Hegistrar's Signature - 105 Aurera 31. Date filed (Month, Day, Year)

State Registrar JAN 15 1999

Zener



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month targer AM Jay 99 3 01 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 306 Sandy Hill Dorchester Rd. Cambridge Hours Min. B. Date of Birth J. (Month, Day, Year) 43 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Yeer 9. Birthplece (State or Foreign Country) New Jersey 10 M 20 F Months Deys 217-42-5110 56 Yrs. Usuet Residence of Decedent 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Dorchester Cambridge 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21613 U.S.A. 306 Sandy Hill Rd. 12. Wes Decedent Ever In U,S. Armed Forces? 14∑ Yes 2 □ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Orlgln? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 16e. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) Coltege (1-4or 5+) Orthopaedic Surgeon Medical 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Evelyn Higgins James Garland Harper 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 306 Sandy Hill Rd., Cambridge, MD 21613 Nancy Harper/Spouse 20b. Pteca of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) Cambridge Crematory | 1-15-99 Cambridge, MD 21. Signature of Funeral Service Licensee Curran-Bromwell Funeral Home, P.A. somwell torrea 308 High St., Cambridge, MD 21613 Approximete e6, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, . List only one cause on each line. tervet Betwe Onset end Deeth Prostate a ith metastasis Immediete Ceuse (Final Year diseese or condition resulting to deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical **Examiner**

Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

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Pages 1 end 2 should be filed within 72 hours efter death with the Meryland

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other traumatic event,

21215-0020

altimore. Maryland

pue the buriel-tran ettending physician for use es the burie Physician/Medical signed by the eld be detached þ Completed been certificate hes Be Certification: To this After t To the Hospital or Attend within 24 hours after deat To the Funeral Director:

The law requires that the death certificate be executed

or Attending Physician:

death.

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completely

Medical

Box 68760,

P.O.

of Vital Records,

Division

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

5 Pending investigation 1 Neturel 2 Accident 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ∏Yes 2 □ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e, Certifier (Check only one)

4 ☐ Homicide

12 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner as stated. 2 Medical Examinar: On the basis of examination end/or trivestigetion, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end menner stated.

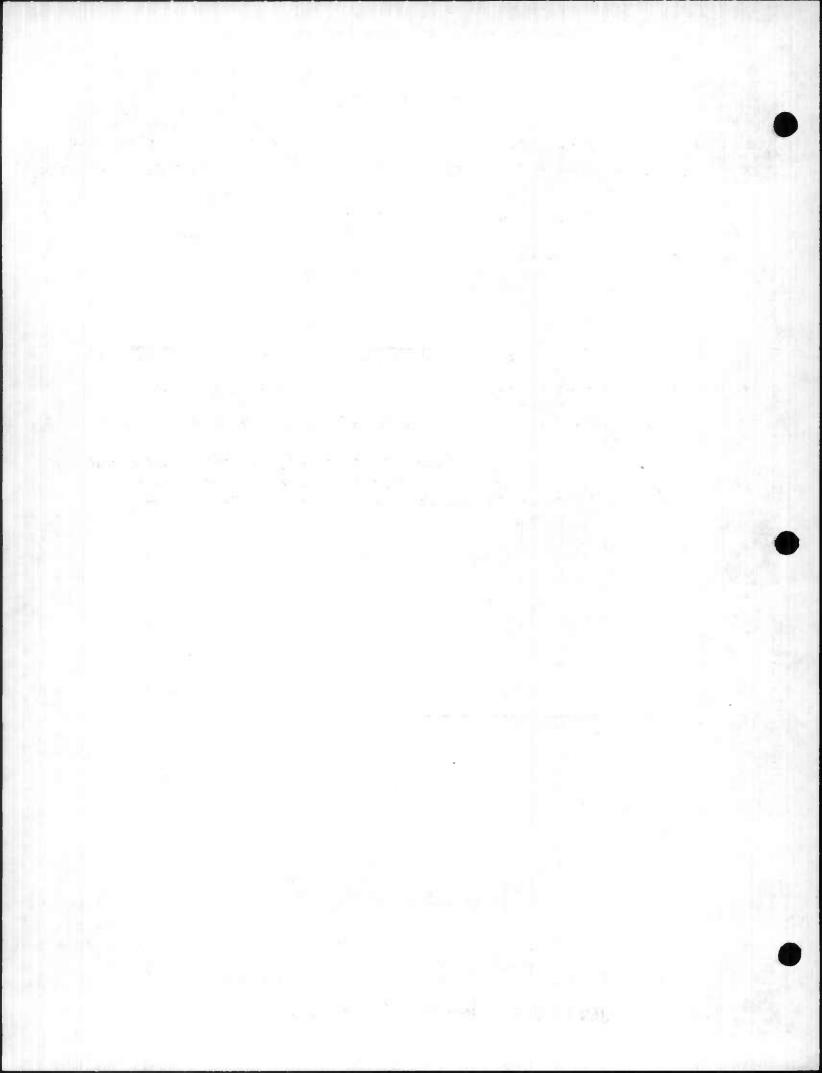
29b. Signeture end title of certifier Carrenan 29c. License number 214349 29d. Dete signed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print), Tanman M.D. EYUP

15 Franklin St. Cambridge, MD 21613

State Registrar

31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture JAN 15 1999

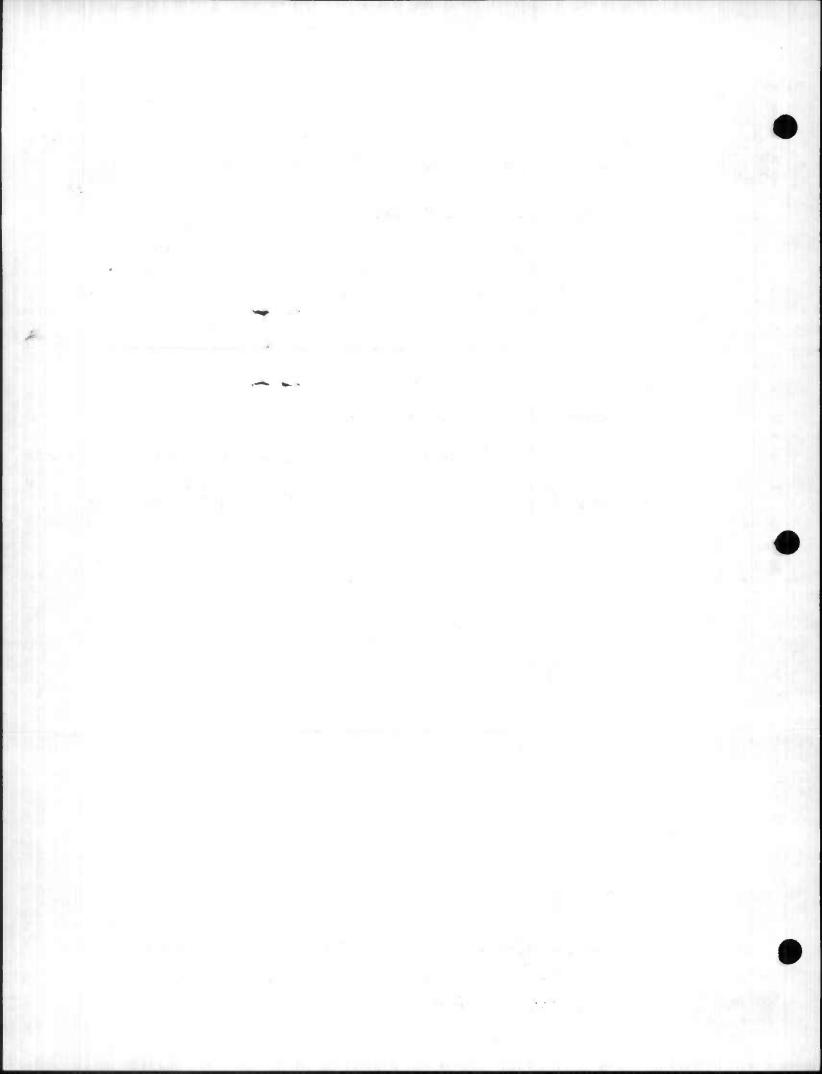


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 22 Dey Doris 1999 Hole Jan. 3:30A. /Medical 4e. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Hillhaven Nursing Home Adelphi Prince George's 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. 8. Deta of Birth Jan 25, 1904 9. Birthplece (Stete or Foraign **Funeral** Days 1 M XX 368-01-5115 94 Yrs. Michigan Director Usuel Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Anne Arundel Davidsonville r than "natural", or Items 23a or 28a-f st the Madical Examiner must be notified Maryland 1 Yes 2 No Director the 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21035 United States 2885 Spring Lakes Drive death Funeral 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Yaar or Datas: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Pages 1 end 2 should be filed within 72 hours efter neat of Health and Mentel Hyglene. and if it is marked other than "natural", or ite wry or other traumatic event, the Modical Example by or other traumatic event, the Modical Example. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: White by Specify: 3 Divorced 4 □ Divorced Completed 15. Decedent's Education 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work dorse during most of working life. DO NOT use retired) (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Charles Harmon Gertrude Wilcox 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zlp Code) Gertrude Lorraine Corridon (daughter) same as #10 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2XX crametion 3 ☐ Removel from State permit. Page Depertment of Important: If any injury or once. Metropolitan Crematory 1/22/1999 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 22. Name end Address of Fecility Donald V. Borgwardt Funeral Home, P.A. 911 4400 Powder Mill Rd. Beltsville, Maryland 20705 ert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, hock, or heart feilure. List only one cause on each line. Approximate Onset end Deeth **Physician** /Medicai Immediate Cause (Final . Pneumonia disaase or condition resulting in death) 2 weeks **Examiner** Due to (or es e consequence of): Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leeding to Immediate causa. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): Box 68760. Physician/Medical the Dua to (or es e consequança of) 98 USB P.O. ed by the e Part II. Other significent conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tss XX No 3 Probably 4 Unknown signed b Arteriosclerotic Cardiovascular Disease of Vital Records. P page 2 should Completed 24b. Were eutopsy findings available prior to 24a. Was en eutopsy Severe osteoarthritis completion of cause of deeth? 1 Yas XXNo 1 Yas 2000 certificate or Attending Physician: director Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpetlent 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes XX No this filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After Division XXNaturel 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street erid Number or Rural Route Number, City or Town, Stete) 4 Homicide XX Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29e. Certifier completely (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D01852 January 22, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul A. DeVore, M.D. 4203 Queensbury Road Hyattsville, Maryland 20781 31. Date filed (Month, Day Near) 2 7 1999 32. Registra & Signeture State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend. 26 1/13/99 SM AACO Health 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** Jennifer Lynn Hamilton 1999 8:30AM Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street end number) Examiner Bello Machre, Inc. Pasadena If Under 24 Hrs. Anne Arundel If Under 1 Year Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1□ M 2X F Months Deys Hours Min Yrs. Director 216-23-2685 18 May 2, 1980 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits d 2 should be filed within 72 hours after deeth with the Merylen th end Mental Hygiane.
7 is marked other than "natural", or frams 23s or 28s-f show traumatic avant, the Medical Expresser must be northed at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Pasadena 10e. Street and Number 10f Zin Code 10g. Citizen of Whet Country? Funeral P.O. Box 979 Cottage 9 21123 United States 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 22 No
If Yes, Give
Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Specify: White Maryland 21215-0020 1 ☐ Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Full Time Student N/A 17. Fether'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Stanley Hamilton Kathleen McGlew 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health end Importunt: If Itam 27 Ia m any Injury or other traum once Kathleen McGlew (mother) 302 Epping Way, Annapolis, MD 21401 altimore, 20b. Placa of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlel 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Gardens 1/9/99 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility John M. Taylor Funeral Home, Inc. Q1. Signature of Funeral Service Litens 147 Duke of Gloucester St, Annapolis, MD Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory errest, **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician end the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last certificete be axecu Box 68760. Physician/Medicai Due to (or es e consequence of): use as t ed by the a 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, by 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes an autopsy performed? Completed pega 2 has 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No certificata Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home & Residence 6 Nother (Specify) Pesidential P 1 Yes 2N No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28a. Date of Injury (Month, Dey Year) Facility 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending after death. 1 | Yes 2 | No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 4 Homicide ŏ filled in Hospital 24 hours Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and menner stated. 29a. Certifier within 24 hor To the Fune complately fi edical (Check only one) To the 29b. Signatu 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Dete filed (Month, Dey, Yeer)

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Dwight N. Fortier,

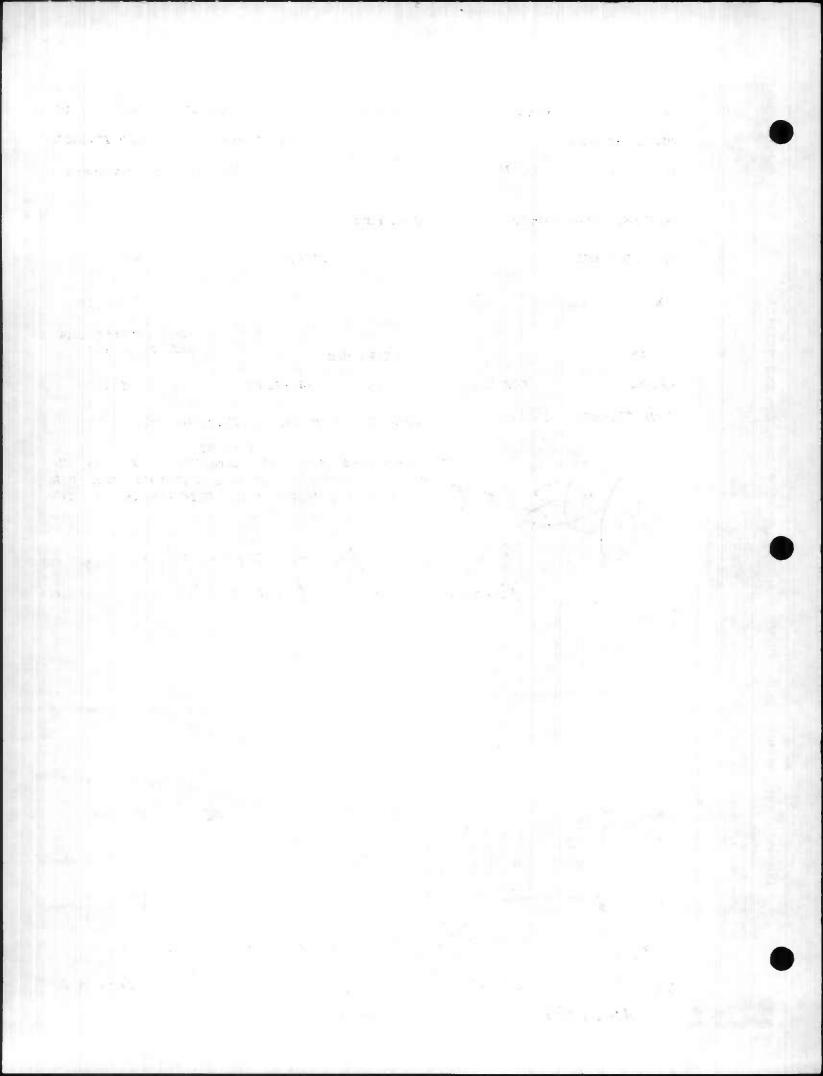
201 Forbes St. Annapolis, MD 21401
32. Registrer's Signeture

erson who completed cause of death (Item 23a) (Type, Print)

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12.5 her treu	19a. Informant's Name/Relationship (Type, Print) SON)		ss (Street and Number or FI RIM DRIVE, MI				1)
-155	20a. Mathod of Disposition		Place of Disposition (A	lame of	Date		City or Town, S	state
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/Medical	Immadiata Calae (Final	13	- dino	Man E	7:120	_		Verla Tal
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within To the comp	29b. Signature and title of certifier	a- De	puty 2	9c. License number	2	9d. Date signe	d (Month, Day,	Year)
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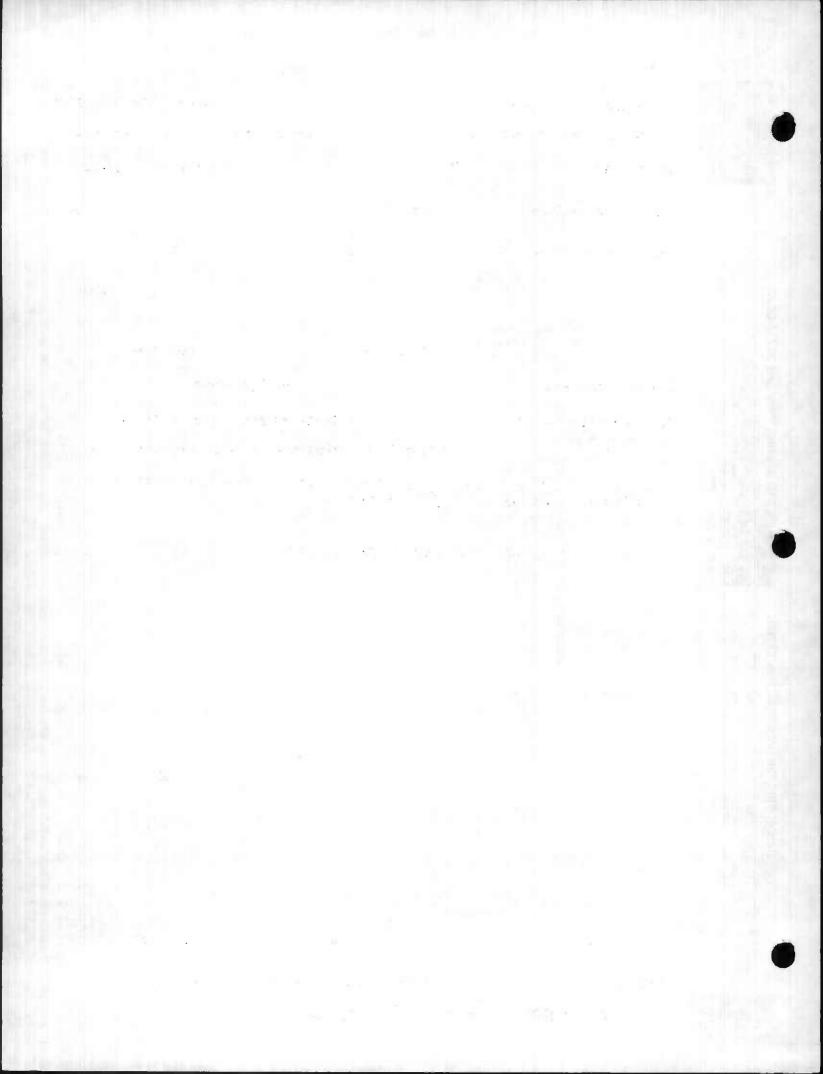
State Registrar 31. Date filed (Month, Day, Yaar)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

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	ineral rector	5. Sociel Security Number 6. Sec 046 60 1847	7. Age (In yrs. 191	lest birthdey) If Under Months Months	1 Year If Un Deys Hou	der 24 Hrs. Irs Min.	8. Date of Birth OCT/31	1 9 67	9. Birth	plece (State or Foreign
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Maryland 21215-0020 d 2 should be filed within 72 hours aff th and Mental Hyglena.		15. Decadent's Edu (Specify only highest gred Elementery/Secondery (0-12)	cation a co <i>mpleted)</i> College (1-4or 5+)	16e. Decedent's Usue (Give kind of wo life. DO NOT us Homemaker	el Occupation rk done during i se retired)	most of working		16b. Kind of B		ndustry
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of Vital Physician: Th	Be Be	25. Wes case referred to medical examiner?	lospital:		Other:		(Check only o			
0 4	al di	27. Manner of Deeth 1 Detural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	DA 4 L 28c. Injury et Work? 1 □ Yes	2		denca 6 Dot		ify)
Division f or Attending after death.	To the Funeral Director: Attart completely filled in by the funeral Medical Certification:	2 Accident 3 Suicide 4 Homicide	28e. Plece of Injury - At he building, etc. (Specify	ome, farm, street, fectory			28f. Location (S City or Tox	Street end Num vn, Stete)	ber or Rui	rel Route Number,
To the Hospital within 24 hours	pletaly filled edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one) 1 Medical Examination (Check only one)	sician: To the best of my kno- ner: On the basis of examinal and menner staled.	wledge, deeth occurred tion and/or investigetion	et the time, det , in my opinion,	e end pleca, a deeth occurre	and due to the	ceuse(s) end m dete end ptece,	enner as end due	steted. to the ceuse(s)
To the within	ro the	29b. Signelure end tille of certifier	200	0 . (. License numi	ber		29d. Dale sign		, Dey, Year)
		Malling	Cho, K		D06054			1-11-99		
		30. Neme end eddress of person who co		n 23e) (Type, Print) America Cot	urt, Da	vidson	ville M	D 21035		
P	State Registrar	31. Dete filed (Month, Dey, Year)	32. Registrar's Signe							

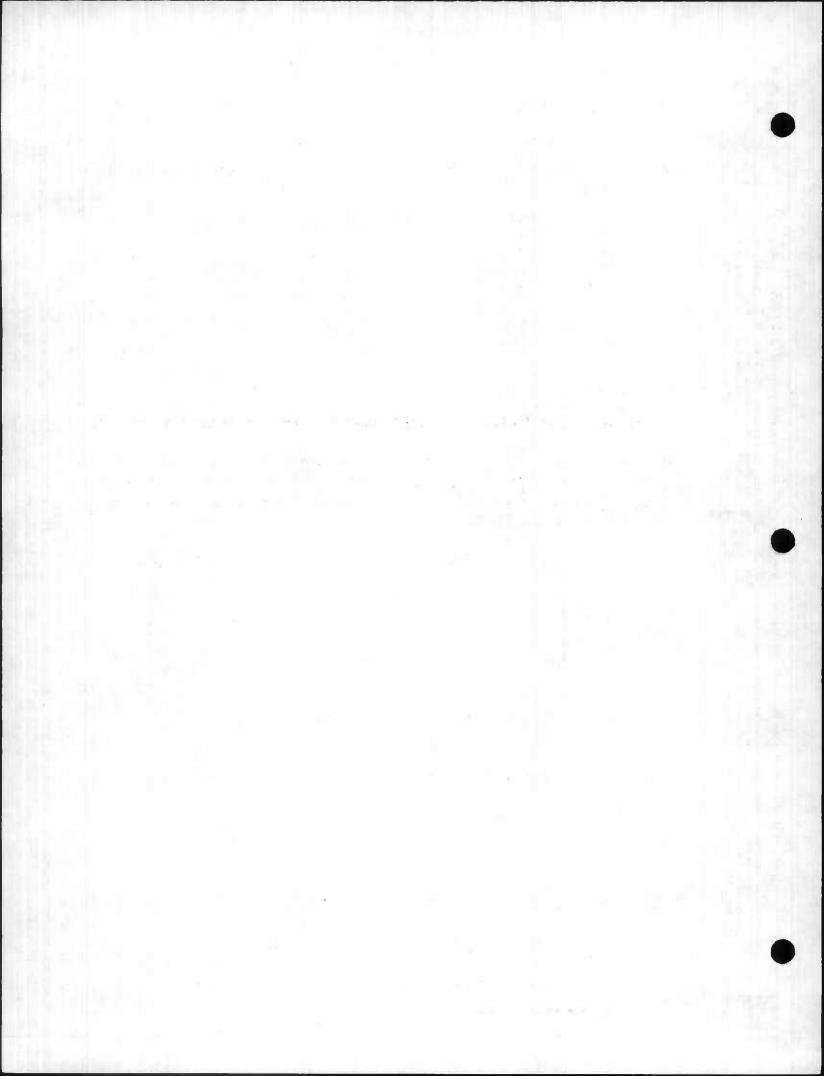
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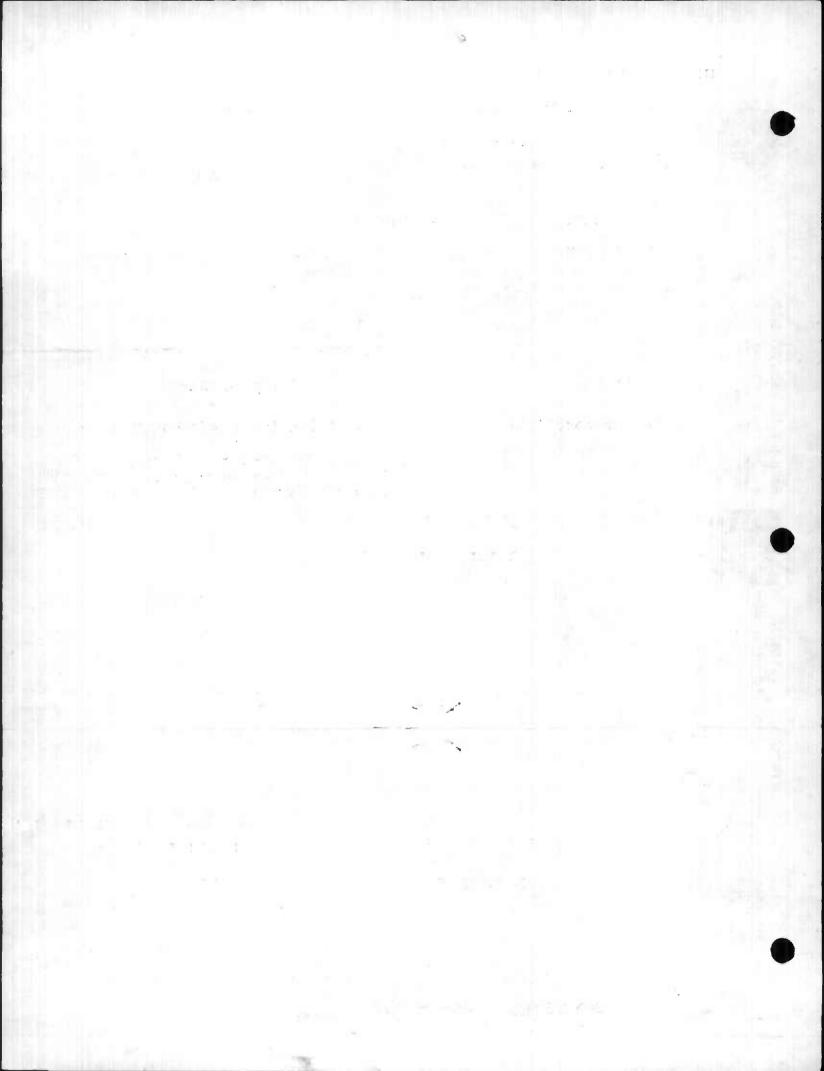
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Stat	te of Maryland / Department of Health and Mental Hygiene 9 9	g	2	1
	Cartificate of Death			

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jan. Owen Floyd Keeler 1999 4:20 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 20, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Hours Months Days 1⊠M 2□ F Country). Virginia 080-24-9196 78 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 TYAS 2 TANO Director Md. Anne Arundel Annapolis 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? "natural", or items 23s or 202 Meadow Gate Drive 21401 IISA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If flam 27 is marked other than "natural", or than any injury or other traumatic svent, the Medical Examinations. 1 Never Married 2K Married 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1939-47 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Automotive Parts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Owen F. Keeler Georgie Von Roy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Margaret C. Keeler / wife 202 Meadow Gate Drive 21401 Annapolis, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 1-11-99 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signeture of Funeral Service Licensee 147 Duke of Gloucester St. Annapolis, 60 Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final difficule colitis disease or condition resulting in death) Examiner Examiner physician and the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yea 2 No 3 Probably 4 Unknown à Records, 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was an autopsy Compression 2 0 No 1 □ Yes 2 □ No 1 Yes Division of Vitai 25. Was case referred to medical examiner? or Attanding Physician: 26. Place of Death (Check only one) Hospital: 1 Dinpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No Medical Certification: To this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dev Year) 1 Netural 2 Accident 5 Pending investigation To the Hospital or Attanding within 24 hours after deeth.
To the Funeral Director: Afte completely filled in by the fune 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 D Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier aire Marata 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elaine Arata MA 705 Melvin Ave. Annapolis, Md. 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 1999 Registrar



DHMH 16 Rev 6/95

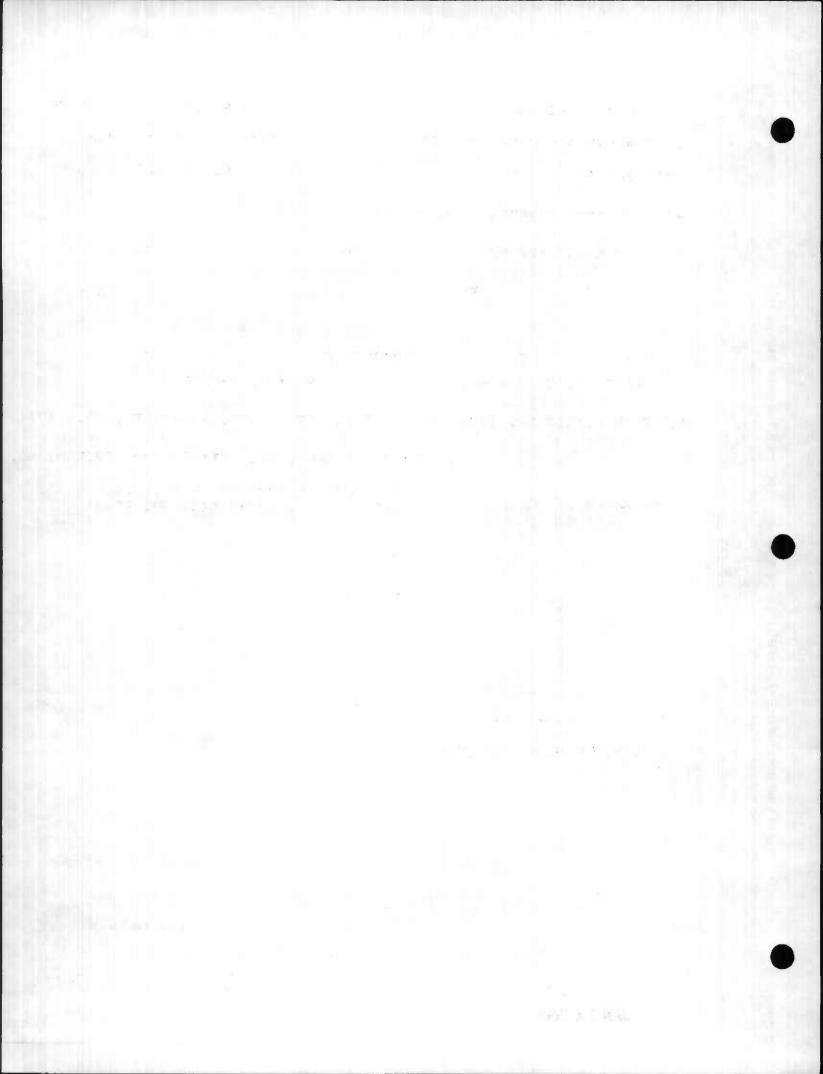


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1 Decedent's Name (First Middle Last) Month **Physician** 1999 11 0639 JAN. VIOLA L. LITTLE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street and number) **Examiner** ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. DEC Month, Day 4 Yeer 923 9. Birthpiece (State or Foreign 7. Age (In yrs. lest birthday) 5. Social Security Number **Funeral** 1 M 2 F MARYLAND 75 Yrs. **Director** 213-22-1859 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location r than "natural", or itama 23a or 28a-f show the Medical Examinar must be notified at Yes 2 No ANNAPOLIS ANNE ARUNDEL MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? US 21403 122 BAY SHORE AVENUE Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian. 11 Meritel Status Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer looparment of Haalth end Mental Hygiene. important: if item 27 is merked other than "natural", or item any injury or other traumetic evant, the Medical Example once. 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married Specify: BLACK altimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOME 12th HOUSEWIFE 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be MARY E. PARKER WILLIAM D. CROWDY SR. 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 122 BAY SHORE AVE. ANNAPOLIS, MD.21403 HARRISON LITTLE SR. (HUSBAND) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Suriel 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) 1/14/99 CROWNSVILLE, MD. MARYLAND VETERAN CEME. 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility WM. REESE & SONS MORTUARY, P.A. 23a. Pert1. Enter the disgrase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, April 214 0.1 April 225 April 226 D. Approximete Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical Cardiac amest Examiner Examiner Probable CNS breed. death certificate be executed physicien and s the buriai-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 88 - esn ed by the a deteched f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Onknown Delated cardiomyopathy þ 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed Hypoprothombinemia certificate has b 2 NO NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 27. Menner of Deeth Neturel 28c. Injury et Work? Certification: After or Attending 5 Pending investigation 1 Yes 2 No 24 hours aftar daath. Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide filled in ! Hospitai 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated. 29e. Certifier To the Hosp within 24 hos To the Fune completely fi edical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 900, Bestgate Road, Annapolis Md21401 BARBARA 300, Suff 32 Registrer's Signeture KEAN 31. Dete filed (Month, Day, Year) JAN 1 4 1999

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible 1830 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** estrh MARION 10, 1999 7:47 PM January /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not Institution, giva street and number) 4c. County of Death Examiner Anne Arundel Medical center Annapolis Anne Arundel If Under 1 Yaar | If Under 24 Hrs. Months Days Hours Min. Birthplace (Steta or Foreign Country) 8. Data of Birth (Month, Day, Year) Oct. 2, 1922 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** Days 1₩ 2□F 216-18-5998 76 Director Maryland Usual Rasidance of Dacedant 10d. tnside City Limits 10a Stata 10b. County 10c. City. Town or Location 28a-f show 1 Yas XX No Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? "natural", or items 23a or 1514 Widows Mite Road 21037 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No IAYas, Giva Yaar or Dates:1942-46 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 14. Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: à 3 □ Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied w Department of Health and Mental Hygien Important: if Nem 27 is marked other the any Injury or other free Shipwright Marine 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Nama (First, Middla, Last) Be Susana Leip William Leitch 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Patricia A. Leitch/ Wife 1514 Widows Mite Road Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) Data 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Lakemont Mem'1. Gardens 1-14-99 Davidsonville, MD of Funeral Sergice Licansea 22. Nama and Addrass of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediata Causa (Final ardiopulmonar por diseasa or condition rasulting in daath) Examiner Examiner netastet the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or Injury thet initieted avants resulting in death) Last Due to (or as a consequence of): pue LIVES physician Box 68760. certificate be Physician/Medical Dua to (or as a consequence of): USB 23b. Dtd tobacco use contribute to the cause of death? Pert II. Other elantiticant conditions contributing to death but not resulting in the underlying cause given in Pert t. Division of Vital Records, P.O. signed by t d be detach 1 Yee 2 No 3 Probably 4 Unknown ilone P 24b. Wara eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 25 No certificate Be 25. Wes case rafarred to medical axaminar? 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Ne Hospital or Attending Ph n 24 hours after death, Ne Funerel Director; After th 28b Time of 28c. tnjury at Work? Certification: 5 Panding 1 Natural 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 ☐ Could not be 3 ☐ Suicida 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide edical 1 Certifying Phyetclan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifian (Check only one) within 2 94 29c. License number 29b. Signetura and titla of comile 29d. Data signed (Month, Day, Year) H0052843 30. Nema and address of person who completed causa of death (Item 23a) (Type, Print) Peter Swaby, M.D. 180 Admira 00 31. Data filed (Month, Day, Yaar) 32 Registrar's Signatura State JAN 1 4 1999 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:05 P.M. Forester 12, 1999 Lewis January /Medical 4a Fecllity Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 6. Sex 100 M 2 ☐ F If Undar 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Deys Hours Min. Yrs. 403-22-6119 73 Oct. 2, 1925 Kentucky **Director** Usual Rasidanca of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Experience. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XX es 2 No Directo Maryland Anne Arundel Edgewater 10g. Citizan of What Country? 10e. Street end Number 10f. Zlp Coda 3636 Beach Drive Boulevard 21037 USA Funeral 12. Wes Decedant Ever in U.S. Armed Forces? 12. Was 2 □ No If Yas, Giva Yaar or Datas:1943-46 Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 Navar Married Married 1 ☐ Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) 6th Mechanic Appliances 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middle, Last) Be Arthur Lewis Rhoda Pratt 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 3636 Beach Drive Blvd. Edgewater, Maryland 21037 Data 20c. Location - City or Town, Stata Donna K. Anderson/ Daughter 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20e. Mathod of Disposition 1 X Buriel 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) 1-19-99 MD Veterans Cemetery Crownsville, MD 21. Signaturo Fynaral Service Licenses 22. Name end Address of Facility George P. Kalas Funeral Home 23a. Fért1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 2973 Solomons Island Rd. Edgewater, MD 21037 Approximata Interval Batween Onsat and Death **Physician** Immediata Causa (Final disease or condition rasulting In death) /Medical Cirrhosis/ Liver Failure 4 years Examiner Dua to (or as a consequenca of): Examiner Hepatoma 2-4 weeks attending physician and for use as the buriel-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consaguanca of): 4 years P.O. Box 68760, Renal Failure Physician/Medicai Dua to (or as e consequenca of): deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Diabetes signed t Division of Vital Records. þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 certificate has 1 Yas XX No 1 Yes 2 No or Attending Physician: 25. Was casa rafarrad to medical axaminar?
1 ☐ Yas 2 No Be 26. Placa of Death (Chack only ona) Hospital: Other: 4 ☐ Nursing Homa 5 ☐ Residanca 6 ☐ Other (Specify) To Minpatiant 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 28a. Data of Injury (Month, Day Year) Certification: After 5 Pending 1 Yas 2 No 24 hours after death. invastigation 2 Accidant 6 Could not be datarmined 3 Sulcide 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) filled in by 4 Homicida Hospital Certifying Physician: To the best of my knowledga, death occurred at the tima, dete end placa, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and placa, and due to the causa(s) and manner stated. 29a. Cartifie within 24 hor To the Fune completely fi Medicai (Check only one) 29c. Licanse number 29d. Date signed (Month, Dey, Year) 29b. Signatura and titla of certifie D44278 January 12, 1999 30. Nama and addrass of person who completed causa of daath (Itam 23a) (Type, Print) A-Carl Suzanne L. Sankey. 171 Defense Highway Annapolis, Maryland 21401 M.D.

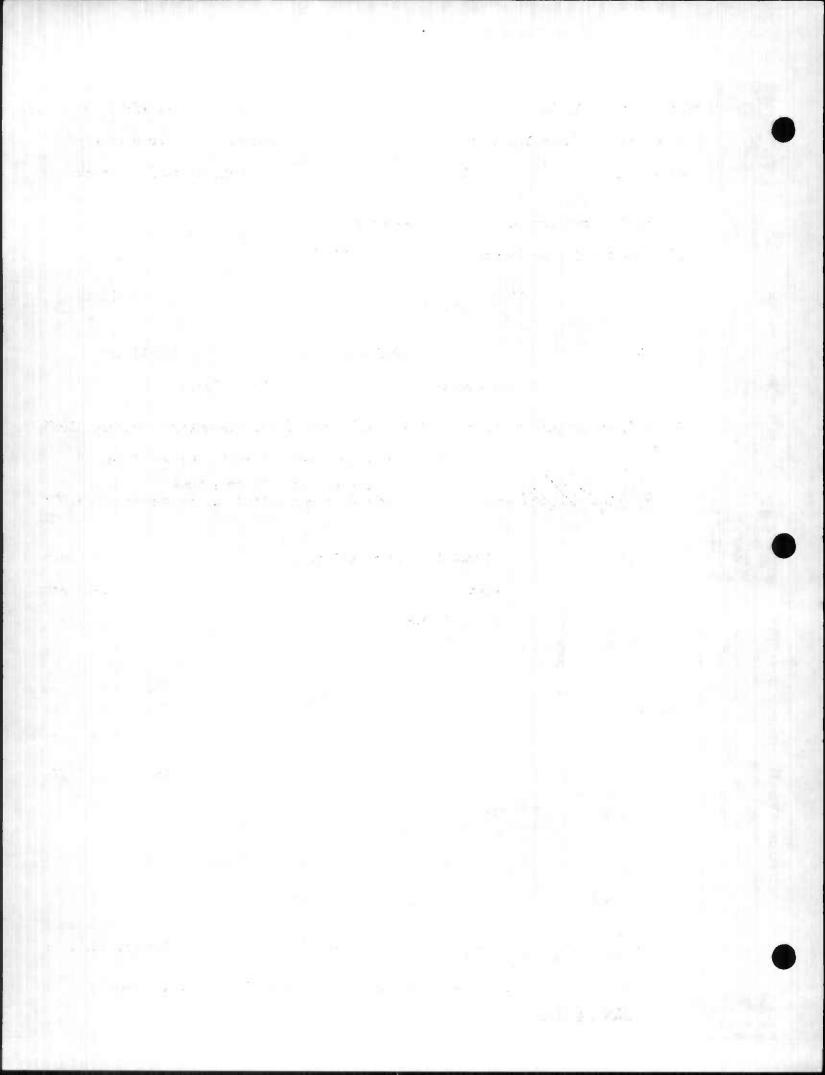
32 Ragistrar's Signatura

Registrar

State

31. Data filed (Month, Day, Year)

JAN 1 4 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month 1999 6 JAN. 2305 HERMAN E. MURRAY JR. 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Death ANNAPOLIS

If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth
Months | Days | Hours | Min. | (Month, Dey, Year) ANNE ANNE ARUNDEL MEDICAL CENTER ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) ₩ 2□ F Yrs. 214-44-7691 53 JULY 24 1945 MARYLAND Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 9 HICKS AVENUE APT. 1 21401 US 14. Race - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married Married 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) EDGEWATER MASONARY BRICK LAYER 17. Fether's Neme (First, Middle, Last) 18, Mother's Name (First, Middle, Meiden Sumeme) HERMAN E. MURRAY SR. PEARLINE JOHNSON 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DOROTHY G. MURRAY (WIFE) 1910 E. COPELAND ST. ANNAPOLIS, MD.21401 20b. Plece of Disposition (Name of cemplery, crematory or other plece)
ANNAPOLIS MEM. GARDENS 1/13/99 ANNAPOLIS, MD. 20e. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility
WM. REESE & SONS MORTUARY, P.A. Harry & elese 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death fmmediate Ceuse (Finel diseese or condition resulting in deeth) unknown Carcinonia Due to (or es consequence of) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest Due to (or es e consequence of) Due to (or as e consequence of): 23b. Did tobacco uaa contributa to the cause of death? Pert ff. Other stanificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings evailable prior to 24a. Wes an eutopsy completion of ceuse of deeth? 1 Yes 2. No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 5 Pending 1 ☐ Yes 2 ☐ No investigetion 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Physician /Medical **Examiner** physician end the burial-transit certificata be executed Box 68760 60 USB for ed by the a Division of Vital Records, P.O. signed t pege 2 certificata has this funeral After Attending death. aftar deat filled in by ò Hospital of 24 hours a Funeral D To the Hosp within 24 ho To the Fune completaly fi

Physician

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Funeral

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r than "naturel", or frems 23s or 28s-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.
ant: If Rem 27 Is marked other than "naturel", or Ite ury or other traumatic event, the Medical Examina

permit. Page Depertment of Important: If eny Injury or page.

Baltimore, Maryland 21215-0020

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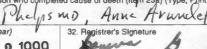
death with

State Registrar

JAN 1 2 1999

W.

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)



un D

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner stated.

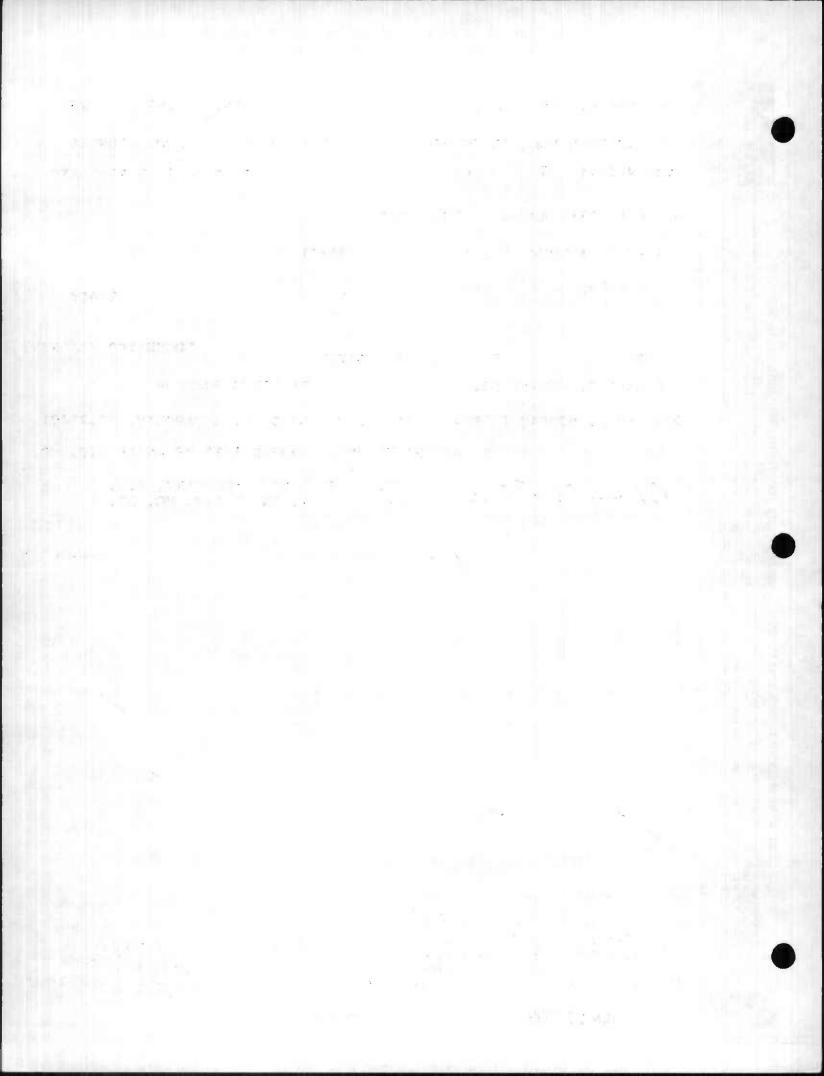
29c. License number

29d. Date signed (Month, Day, Year)

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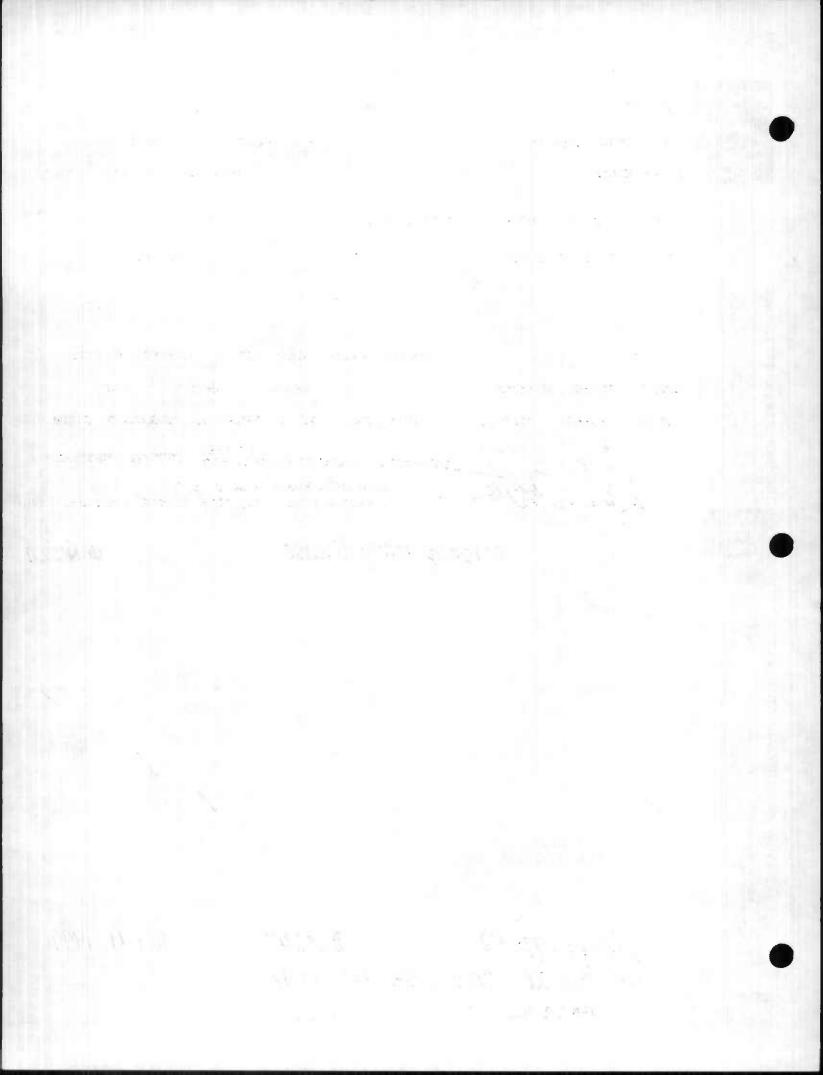
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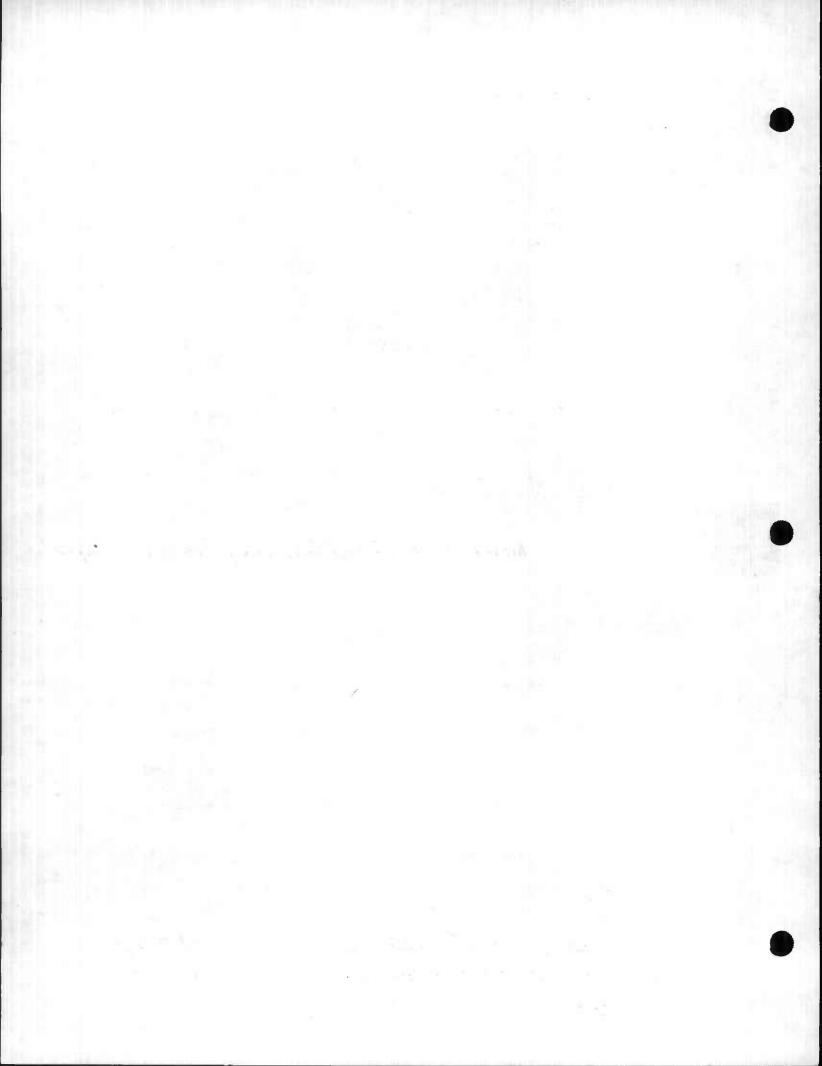
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ath v	545 SHORT CURVE	-			21061				U.S.A.		
filed within 72 hours after death with the Manyland Hygiene. ther than "natural", or items 23a or 28a-f show out, the Modical Examiner must be notified as Completed by Funeral Director.		12. Was Decadant Armad Forcas? 1 ☐ Yas 2 💆! If Yas, Giva Yaar or Datas:	and the same	If Yas, s	cedant of F pecify Cub 2 No	an, Maxican	gin? (Specify n, Puarto Rica	Yas or No- in, atc.)			tc.
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State of Maryland / Department of Health and Mental Hygiene 99 0 834

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	Decedent's Name (First, Min TO)	ddle, Last) AN OTTENDO!	DE MATUR	MOOD			2. Date of De Month	Day Y	3. Time of Death
/Medical				MOOD			JANUA		
Examiner	4a Facility Name (If not Institu Holy Cross H		umber)			4b. City, Town, or L Silver S		4c. County of Montgo	
Funeral Director	5. Social Security Number 499 18 6184	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs	. last birthday) Yrs.	Months Days		8. Date of Bir (Month, Da AUG/5/	th Year) 1923 M	D. Birthplace (State or Fore Country) IISSOUTI
and water	Usual Residence of Decedent 10a. State 10b. Cou	nty	10c. C	ity, Town or Lo	ocation				10d. tnside City Lim
Se-I showing and sector	MD Mont	gomery	Ro	ckvi11					1 ☐ Yes 2 🔀 l
ifer death with the Mei r Items 23s or 28s-1 si finer mail to modified Funeral Director	10e. Street and Number 4803 Aspen H	Hill Road			10f. Zip Code 20853			10g. Citizen of Wh USA	at Country?
within 72 hours effer death with the Meryland ene. than "natural, or items 23a or 28a-f show he Medical Evariner must be notified at empleted by Funeral Director		Armed Flarried 1 2 Yes	2□No		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White
in 72 ha "natur oferted	15. Decec (Specify only hig	dent's Education thest grade completed		(Give	dent's Usuat Occu kind of work done DO NOT use retin	during most of work	ring	16b. Kind of Busin	ness/Industry
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Mental H Mental H mrked oth artic even	17. Father's Name (First, Midd	TARREST				100000000000000000000000000000000000000	and a second	Maiden Sumame)	4.02
2 shou and M la mart l	19a. Informant's Name/Reletic			19b. Maili	ng Address (Stree			er, City or Town, St	ete, Zip Code)
of Health Mem 27 I	Susan Showard	d (daughter			_				
Peges nent of int: If it iry or o	20a. Method of Disposition 1 Buriel 2 Cremetic 4 Donation 5 Other				osition (Name of metory or other pla tan Crem		- 1		
permit. Peg Department Important: I any injury o phos.	21. Signature of Funeral Servi	Ce Licensee	quel	/				n Service	S
Examiner	disease or condition resulting in deeth)	a//(C	Due to (or es e conse	quence of):	cell lu	ngla	neey	2442
rificate be assouted to physicien and as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	S b	Due to (or es a consec	quence of):				
hysic the bi	that initiated events resulting in death) Last	С	Due to (or es a consec	quence of):				
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net the death certif d by the ettending letached for use as Physician/Me	Part It. Other significant cond		death but not re	sulting in the u	inderlying cause g	iven in Part I.	1 🗂	Yes 2□ No 3	Probably 4 Unkn
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The lew requires that the death certificate has been signed by the ettending page 2 should be detached for use a Completed by Physician/Me	25. Was case referred to med exeminer?	icat				ematory 1/11/98 Alexandria VA Address of Facility Funeral & Cremation Services hurch VA 22046 If dying, such as cardiac or respiratory errest, Approximatinerval Bei Conset and Approximatinerval Bei Conset an			24b. Were autopsy finding available prior to completion of cause of death? 1 Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year **Physician** 10:45 PM Antonio L. Manlapaz, Sr. 1999 January 6 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1317 Blackwalnut Ct. **Annapolis** Anne Arundel If Under 1 Year 8. Dete of Birth (Month, Day, Year) June 12, 1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplece (Stete or Foreign **Funeral** Months Hours 1X M 2□ F 84 Yrs. 215-76-2196 Phillipines Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or herrs 23s or 28s-f show 1 Yes 2 XNo Director Md. Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1317 Blackwalnut Ct. 21403 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify SpecifyPacific Islandet 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hyglens. Other than Elementary/Secondary (0-12) Maintainence Banking 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be is marked of Pages 1 and 2 should be Francisco Manlapaz Unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health as important: If Item 27 is any injury or other tras once. Melania Manlapaz / wife 1317 Blackwalnut Ct. Annapolis, Md. 21403 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 1-11-99 Annapolis, Md. 22. Name end Address of Fecility John M. Taylor Funeral Home, Inc 21. Signeture of Funeral Service Licenses 147 Duke of Gloucester St. Annapolis, Md. 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart teilure. List only one cause on eech tine. Approximete Interval Between Onset and Deeth Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es a consequence of): Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 3 Probably 4 □ Unknown 1 Yes 2 No þ Completed 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? canco 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 8 25. Wes case reterred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1. Netural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a, Cartifier Medical (Check only one) mination and/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the ceuse(s) 29b. Signature end title of certifie 29c. License number dress of person who completed cause of death (Item 23a) (Type, Print) hel ns MD Ann Aungolis 31. Date filed (Month, Day, JAN 12 32. Registrar's Signetura State Registrar

DHMH 16 Rev 6/95

Box 68760 P.O. Records, of Vital

Division

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State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** 6, January 1999 Evelyn Mae McIntyre 6:00 am /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Genesis Eldercare Anne Arundel Severna Park 8. Dete of Birth (Month, Day, Year) Sept 27, 19 If Under 1 Year 5. Sociel Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2MF Months Deys Hours 82 Yrs. 1916 488-18-2348 Director Virginia Usual Residence of Decedent 10e State 10d. Inside City Limits 10b. County 10c. City. Town or Location the Maryle 7 is marked other than "natural", or Items 23s or 28s-f abov traumatic event, the Modical Examinat must be notified at MD 1 ☐ Yes 2 No Anne Arundel Severna Park Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 621 Park Road 21146 USA Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 11. Merital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian. Black, Whita, etc. 2 should be filled within 72 hours effer and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White altimore, Maryland 21215-0020 à 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Five and Dime Elemantary/Secondary (0-12) College (1-4or 5+) Owner and Operator 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Fethar's Nema (First, Middle, Last) Be Bernard Stone Ada Mae Carner Semil Pages 1 and 2 sh.
Department of Health and h.
Important: if ken 27 is meany injury or other 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Neme/Ralationship (Type, Print) Jacqueline Petrakis/daughter 621 Park Road, Severna Park, MD 21146 20b. Place of Disposition (Neme of cemetery, crematory or other place)
Glen Haven Cemetery 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Jan 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD 1999 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
Barranco & Sons, P.A. Severna Park Funeral Home enture of Fill eral Service 195 Gov. Ritchie Hwy., Severna Park, Do not enter the mode of dying, such es cerdiec or respiretory errest, eart failure. List Onset end Deeth **Physician** Immediate Causa (Finel disease or condition resulting in deeth) /Medica ARTEHOSCIERUTIC CARDIOVASCULAR 2 46AM Examinor Dua to (or as a consequance of): DISBACE Examir certificate be executed physician end s the burial-trans Sequantially list conditions, if eny, leeding to immediate ceusa. Enter Underlying Ceuse (Diseese or Injury that initiated avents resulting in deeth) Lest Due to (or es e consequance of): Physician/Medical Due to (or es a consequence of): 98 1 esn P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown signed by DEMENTIA à Division of Vital Records. 8 24b. Ware autopsy findings aveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy page 2 2 PNo 1 ☐ Yes 2 ☐ No 1 Yes 25. Was cese referred to medical examinar? Be 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 10 After this 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. tnjury et Work? I or Attending P efter death. I Director: After I 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be datermined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours eff To the Funeral Di completely filled in 1 Certifying Phyaicten: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end mennar es stated.

2 Madtcat Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 21776 JAOUANY 30. Name and addrass of person who completed ceuse of deeth (Item 23e) (Type, Print)

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32. Registrer's Signature

MUNDRA

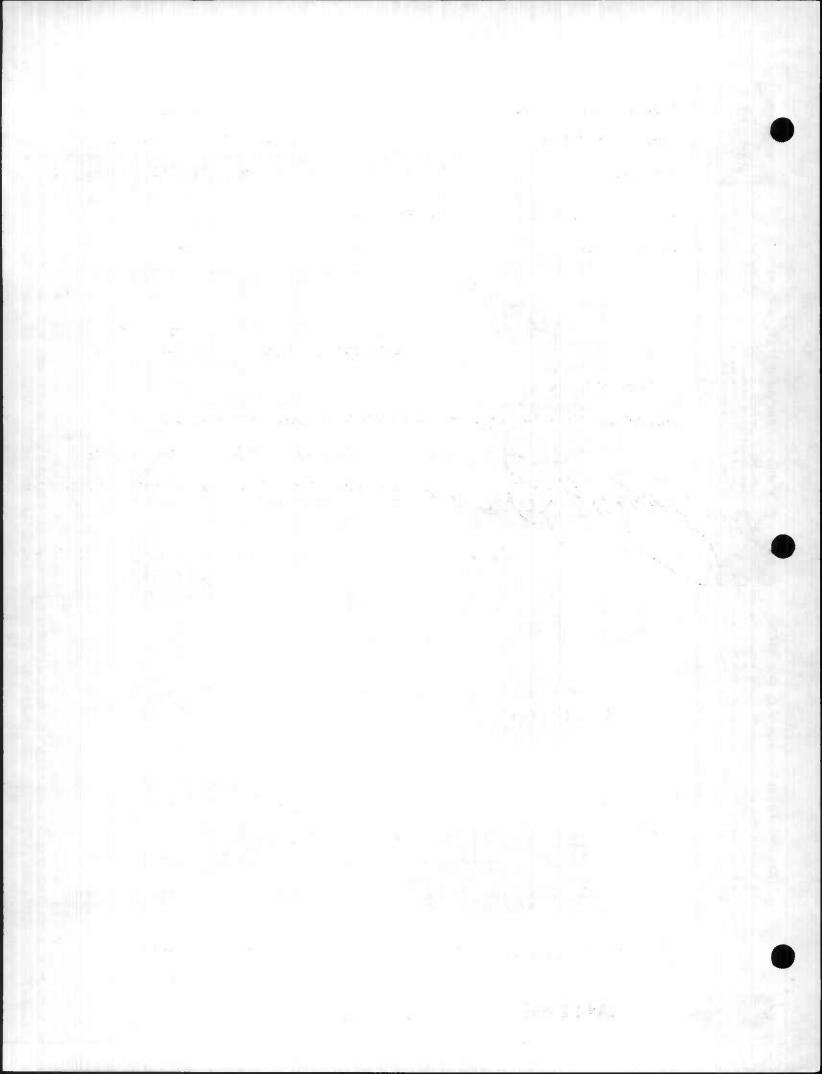
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Registrar

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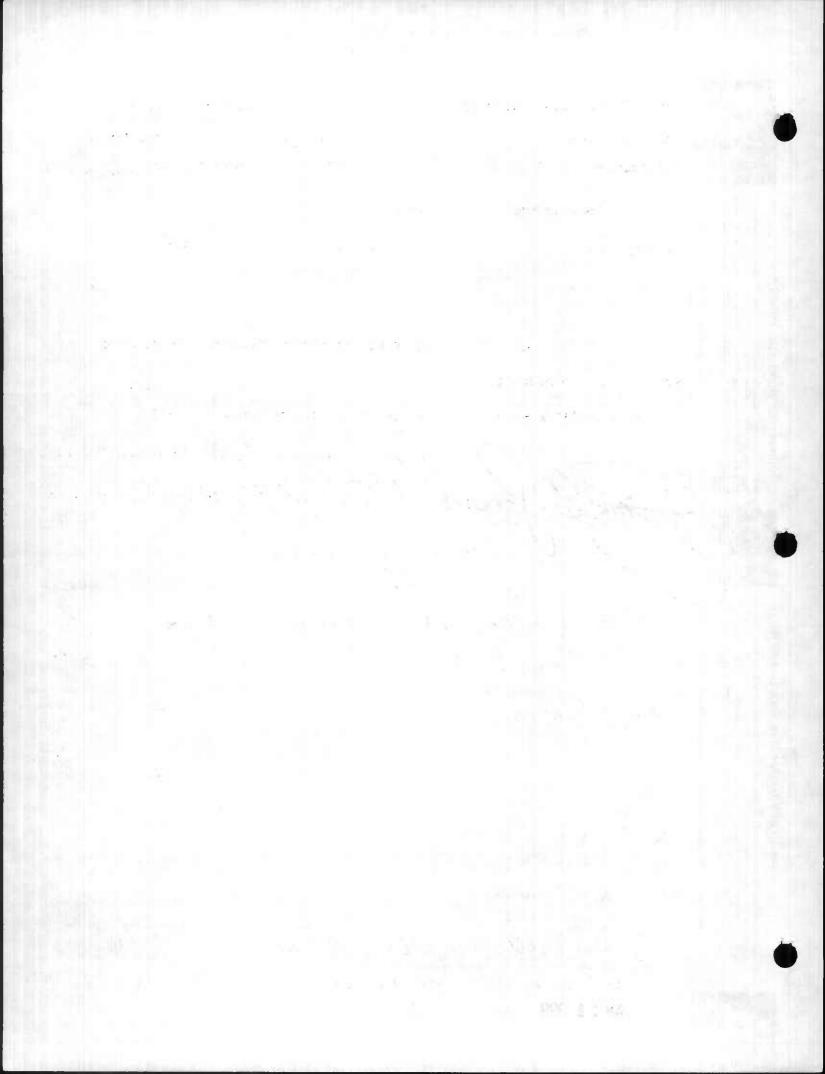
31. Dete filed (Month)



State of Maryland / Department of Health and Mental Hygiene Amend. 16a 1/12/99 Sm AACO Health Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** 9:00 am Howard Marshall January 9, 1999 Nickelson · /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 44 Stone Drive Pasadena If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 26, 1932 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Hours 12 M 2 F Months Days Min. 66 115-24-8501 Director New York Usual Rasidance of Decedent the Maryland 10d. Insida City Limits 10a. State 10b. County 10c. City. Town or Location tem 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Madical Examinat must be notified at MD Anne Arundel Pasadena 1 Yas 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 USA 44 Stone Drive Funeral daath 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Ever In U,S. Armed Forcas?
1 Yas 2 20 No 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. White permit. Peges 1 end 2 should be filed within 72 hours effer of the strain of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Madical Exemp 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: If Yes, Give Year or Dates: 2 Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) rector Healthcare Finance Coilege (1-4or 5+) 5+ Elemantary/Secondary (0-12) Healthcare 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Sam Nickelson Shirley Sachs 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. informant's Name/Ralationship (Type, Print) Rosalie Nickelson/ wife 44 Stone Drive, Pasadena, MD 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) Jan Data 12 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramovai from State Pinelawn, New York 1999 Beth Moses Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Consee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Sever int caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 495 Gov. Ritchie Hwy., Severna Park, MD 21146 Approximata interval Batween Onsat and Death Physician /Medical mediate Cause (Fi egoira toly Examiner Atele YOUS ! Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants pue Exa muscle wentres physician the burta Box 68760. Uspira to re Physician/Medical Dua to (or as a consequanca of) rasulting in daath) Last 88 0 980 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hupertensin Division of Vital Records, 2 8 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of cause of death? page 2 certificate has 1 Yas 2000 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical examinar? Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 | Yes 2 000 10 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Mannar of Death 28b. Tima of 28c. Injury at Work? Certification: or Attending 1/ Natural 2 Accidant 5 Panding invastigation after death. 1 Yas 2 No tha 6 Could not ba 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida To the Hospital within 24 hours a To the Funeral C Hospital 29a. Cartifiar 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completaly (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifia of dagth (itam 23a) (Type, Print) brue # 202/Glesburnie, MD Hosp, Youl MIS

32/Registrar's Signatura

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3. Tima of Death Month **Physician** David 10 1999 4:30 PM Herman Owen Jan. /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4e Facility Nema (If not institution, give street end number) Examiner Genesis Eldercare - Spa Creek Center Annapolis Anne Arundel If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sax 1 M 2 □ F If Undar 1 Yaar Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Deys 216-18-5925 Virginia Director Sept. 9, 1917 Usual Rasidance of Decedant the Maryland 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or forms 28a or 28a-4 ahow other traumatic event, it a Medical Examiner must be notified at 10a Stata 10h County 1 Yas 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1026 Harbor Drive 21403 USA Funeral death 12. Was Decedant Ever in U,S. Armed Forcas? 1Ă Yas 2 □ No If Yas, Giva Year or Datas: WW II Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14 Race - American Indian Black, Whita, atc. 12 should be filed within 72 hours effer on and Mental Hygiene. 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) U.S. Naval Academy Supervisor 12 18. Mothar's Nama (First, Middla, Meiden Surnema) 17. Fathar's Nama (First, Middla, Last) David Spencer Owen Margaret Britts 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Peges 1 and 2 sh Depertment of Health and Important: if Item 27 is m any fnjury or other traum 00058. Mary E. Owen / wife 1026 Harbor Drive Annapolis, Md. 21403 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 □ Crametion 3 □ Ramoval from Stata Hillcrest Cemetery 1 - 12 - 99Annapolis, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name and Addrass of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funaral Sarvice Licensas 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrast, shock, or heart failure. List only one cause on each line. Annapolis, Md. 21401 Onsat and Death **Physician** Immediate Cause (Final disaasa or condition rasulting in daath) /Medical Examiner Examiner physician end s the buriel-trens Sequantially list conditions, if any, laading to immadiate causa. Entar Undartying Causa (Disaasa or injury that initiated avants certificate be execu Box 68760 Physician/Medical as the Dua to (or es e consequence of): resulting in death) Last ed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use coptribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by the Division of Vital Records. P 2 24b. Wera autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy Completed Deen pege 2 hes 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No certificate Be 25. Was casa rafarred to medical 26. Pleca of Death (Check only ona) 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) To After this 27. Manner of Deeth 28b. Time of 28d. Dascribe how injury occurred Certification: 28c. tnjury at Work? f or Attending P efter deeth. I Director: After 5 Panding invastigation 1 Netural 1 Yas 2 No 2 Accidant 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 ☐ Could not be 3 Suicida 28a. Plece of Injury - At home, farm, streat, factory, offica building, atc. (Specify) datarmined 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the ceuse(s) and mannar as stated.
2 Madical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d, Data signed (Month, Dav. Year) 29c. Licensa number anuar

of deeth (Item 23e) (Type, Print)

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32 Registrar's Signetura

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31. Dete filed (Month, Day, Year)

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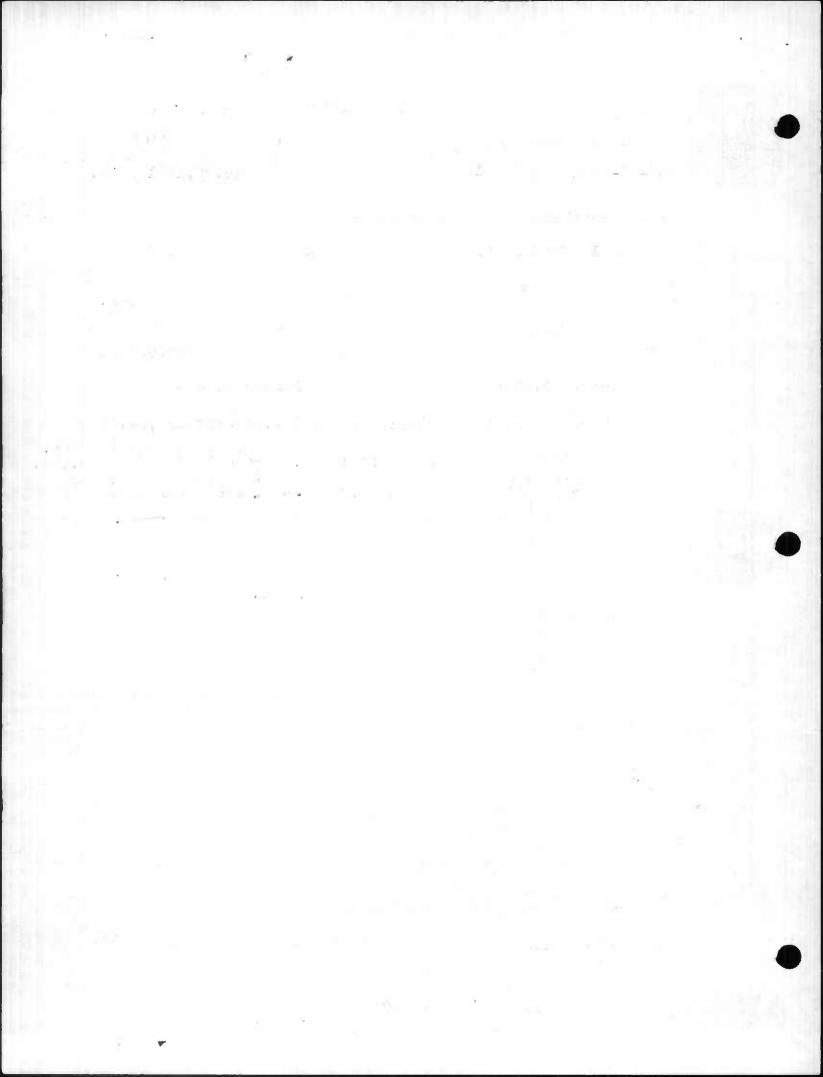
State Registrar And the second second second second second second

State of Maryland / Department of Health and Montal Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month aka Jennifer L. Pine 1999 1:21.AM Jennifer Pine Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Allegany Memorial Hospital If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 8. Data of Birth (Month, Dey, Ye Jan 25) 7. Age (fn yrs. last birthday) Birthplaca (Stata or Foraign Country)
 Pa 5. Social Security Number 6. Sex **Funeral** 1□ M 2∰F 208-60-3535 Yrs. Director Usual Residence of Decedent the Maryland 10e State 10b, County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov event, the Medical Examiner must be notified at Franklin 1 ☐ Yas 2 No Pa. Mercersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Department of Health and Mentel Hygiene. Important: if them 27 is marked other than "net-many highly or other traumating." 17236 11113 Hunter Rd. USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 Yes 2 No If Yas, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grada complatad) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collaga (1-4or 5+) Student Pub.schools 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Meiden Sumame) Be George E. Pine Panela C.Leese TOT 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 11113 Hunter Rd., Mercersburg, Pa. 17236 George E. Pine 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20c Location - City or Town, State Montgomery Twp. 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata Franklin Co., Pa. 4 ☐ Donation 5 ☐ Other (Specify) Pine Grove Cem. 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Lininger-Fries F. Home 47 N. Park Ave., Mercersburg, Pa. 17236 m. 23a. Part1. Enter the disease, or complications that caused the Albarth. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Betwaen Onsat and Death **Physician** /Medical Immediate Ceusa (Final diseasa or condition resulting In daath) 1 hour a. Multiple head and neck trauma Examiner Due to (or as a consequance of): Examiner Hospital or Attending Physician: The law requires thet the death certificeta be executed buriel-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as e consequence of): physician s the buriel Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed certificata 25. Was case raferred to medical axaminer? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funerai 27. Mannar of Death 28c. injury at Work? Date of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how Injury occurred After single truck accident 5 Pending Investigation 1 Natural Injury deeth. 1 Yas 2 No $12:05A^{M}$ within 24 hours after deeth To the Funeral Director: , completely filled in by the 1/1/99 Dassanger t 28f. Location (Street end Nul City or Town, Stete) thrown from tri in by the 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicida (Frittenwastr) Pa Rt 484 Road edical 1 Certifying Physician: To the best of my knowledge, daath occurred at tha time, dete and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar statad. 29a. Certiflar 29b. Signature and title of certifie 29c. Licensa number 29d. Data signed (Month, Day, Year) Jan 1 1999 Ex D 09157 Dpty Med and address of person who completed cause of daath (Item 23a) (Type, Print) 124 w 3rd st Cumb Md 21502 M.D. Snow, Pau1 31. Date filed (Month, Day Year) JAN 2 32. Registra s Signature

DHMH 16 Rev 6/95

State Registrar



Registrar

State

31. Date filed (Month.

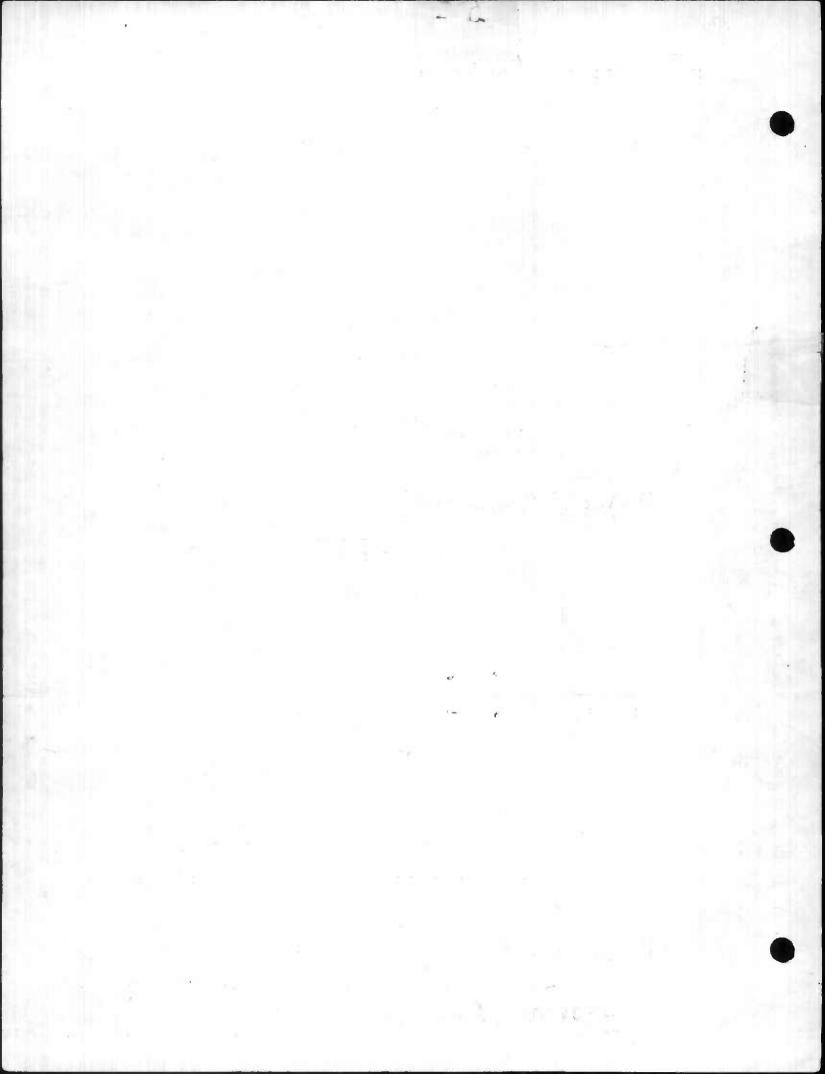
Day, Year)

DHMH 16 Rev 6/95

32. Registrar's Signatura JAN 27 1999

9. Sports

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				a. y				Death		leg. No.		
		1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month	th	Year	3. Time of Death
Physicia /Medic		HINTON IRA SMIT	Н						JAN.	12,	1999	4:43PM
Examine		4a Facility Name (If not Institution, give	street and number)					4b. City, Town, or L	ocation of Deeth	4c. Coun	ty of Death	
#		GINGERCOVE HEAL	TH CARE C	ENTE	R		3	NNAPOLIS		ANNE	ARUN	DEL
Funeral Director		5. Social Security Number 6. Social Security Number 049-10-2843 Usual Residence of Decedent	ex 7. Ag XM 2□F	e (In yrs. 8	// Ast birthday) 7 Yrs.	If Unde Months	r 1 Year Deys	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da) AUG . 21		9. Birthp Cour MARY	placa (Stata or Foraign http) LAND
how		10a. Stete 10b. County	1571	10c. Ci	ly, Town or Loc	ation					1	0d. Inside City Limits
Ma-f	cto	MARYLAND ANNE ARU	NDEL	ANN	APOLIS							1 ☐ Yes 2 No
# 5 × 5	Director	10e. Street and Number				10f. Zi	p Code			10g. Citizen o	f What Cour	ntry?
ath w	rai	6210 RIVER CRESCE					401			UNITED		
15-0020 n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates: 1	No		/as Dece Yes, spe ☐ Yes		dispanto Ortgin? (Spen, Mexican, Puerto Specify:	Pecify Yes or No- Pican, etc.)	8	ace - Americ leck, White, hity: WHI!	etc.
Maryland 21215-0020 d 2 should be filed within 72 hours aff th end Mental Hygiene. 7 is marked other than "natural", or treumatic event, the Medical Exam	Completed	15. Decedent's Ed (Specify only highast gra- Elementary/Secondary (0-12)	ucation da complated) College (1-4or 5		1000		ial Occup ork dona isa ratire	pation during most of world)	king	16b. Kind of	Business/In	dustry
a filed wall Hygier other treet, the		12	5+		CAPT	AIN		18. Mother's Nam	o (Eisat Middle		NAVY	
Vland uld be file Mental Hy rked othe	o Be	17. Father's Neme (First, Middla, Last) IRA SMITH						LUCILE			smaj	
should and Men and Men and Men and Men and marke	7	19a. Informent's Name/Reletionship (7	vpe, Print)		19b. Malling	Addres	s (Street	and Number or Ru			m, Stata, Zip	Code)
Ma nd 2 a lith or 27 is r treu		MARY M. SMITH	(WIFE)		6210	RIVE	R CF	RESCENT DI	R. ANNAP	OLIS,	MD. 2	1401
Ore,		20a. Method of Disposition 1 □ Burlel 2 🕱 Cremetion 3 □			Placa of Dispos cematary, crem			1	Date	20c. Location		
Baltim permit. Par Department Important: any injury once.		4 Donation 5 Other (Specify 21. Signature of Fugure Service Lieun		FT	LINCO				-14-99	BRENTW	00D,	MD.
Baltin permit. Pa Departmen important: any injury.		Metal	Chi	The same	714	7 DU	IKE (F GLOUCE	STER ST.	ANNAP		L HOME, INC. MD. 21401
Physician		23a. Peri 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each li	I the deel	th. Do not ente	r the mo	de of dyl	ng, such as cardiac	or respiratory ar	rest,	1	Approximate Interval Between Onset end Death
/Medical Examiner		Immediate Ceuse (Finel diseese or condition resulting in death)	8.		non							1 wh
P is	iner		0	o P D	or as a consequ)	ience ot):					4RS
oxecute in end rial-trans	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	0.	Due to (or as a consequ	ience of)	:					
68760, tificeta be executed g physician end es tha burial-transit	edicai	Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (d	or es e consequ	ence of)	:					S Wall
tha death certify the ettending y the ettending ached for use e	Physician/M		d									
D. Es a dea	sici	Part II. Other significant conditions co	ontributing to death b	ut not res	sulting in the un	derlying	cause gi	ven in Part I.	23b. Dld 1	obacco uae	contribute t	o the cause of death?
S, P.O. BOX s that the death cent and by the ettendin ed detached for use	y Phy								15%	res 2□ No	3 □ Pro	bably 4 Unknown
Records, P ne law requires that a has been signed to	Completed by	0.760								an autopsy med?	ev	fere autopsy findings vaileble prior to empletion of cause death?
The fa	Com								101	es 2K No	1 [☐ Yes 2☐ No
Vital P	Be	25. Was case referred to medical examiner?	11 2				- 1 -		th (Check only o			
of Vita Physician: rithis certific and director,	P	1 ☐ Yes 2 1 No	Hospital: 1 Inpatie	_	ER/Outpatient	-	UA		ome 5 Resid			ty)
Attending P r death. ector: Atter t by the funers	ation:	27. Manner of Death 1 Netural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	M	28c. inju Wo 1	ryat urk?]Yes 2□No	28d. Describe h	now Injury occ	urred	
Division of Vita With Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Inj building, etc	ury - At h c. (Speci	ome, farm, stre	et, facto	ry, office		28f. Location (5 City or Tov	Straat and Nu m, Stata)	mber or Run	al Routa Number,
To the Hospital within 24 hours of To the Funeral of completely filled	edicai		ysician: To the best of liner: On the basis of and manner sto	examina								
Vithin To the	Me	29b. Signature end title of certifler				29	c. Licen	se number		29d. Date sig	ned (Month,	Day, Year)
		1000	lleen				030	718		JANUAF	Y 13,	1999
		30. Name and address of person who o					7 4	INA DOT TO	MD 01/	.0.1		
Stat	te	JOHN D, JACKSON M, 31. Date filed (Month, Day, Year)	32. Region			(KWA)	Lan	NNAPOLIS,	MD. 212	IU I		

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	4 December 1	- /F"	Ha A and		061	rtificate c	Dealli		2. Date of Dec	Reg. No.		3. Tima of Death
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Medical			on, give street and n				4b. City, To	wn, or Lo	cation of Deeth	1 4c. Count	-1-	ANIA
aminer	906 Byv						Anna	apoli	S		e Aru	nde1
eral	5. Social Security I		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	er If Under		9 Date of Rid	lln.		lace (Stete or Fore
ctor	058-26-01		10XM 2□ F	69	Yrs.	WOTHIS Du	73 110013	101111	Feb. 2	y, Year) 5, 1929	Ok	lahoma
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Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Deeth Day 7:35 AM AIS ASKER JANUARY 11 1999 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) H Under 1 Yeer | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) SINAI HOSPITAL NONE 9. Birthplace (State or Foreign Country) 5. Sociel Securify Number 7. Age (In yrs. last birthday) Months 1 ☐ M 2 ☑ F Yrs. 47 MARCH 22 1951 MARYLAND 212-60-1995 Usual Residence of Decede 10d. Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Numbe 1218 BARBUD LANE 21403 US 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Amarican Indien, 11. Marital Status Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elemantery/Secondery (0-12) College (1-4or 5+) CHESAPEAKE MANOR 12th MEDICINE AIDE NURSING HOME 18. Mother's Nema (First, Middla, Maidan Sumeme) 17. Fether's Neme (First, Middle, Last) JAMES GRIFFIN HELEN WOOD 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) GEORGE TASKER (HUSBAND) 1218 BARBUD LA. ANNAPOLIS, MD. 21403 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) ANNAPOLIS MEM. GARDENS 1/15/99 ANNAPOLIS, MD. 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility WM. REESE & SONS MORTUARY, P.A. Lavry 23a. Pert1. Enter the riseese, or complications that caused the death. Do not enter the mode of the find of spiral and of respiratory arcest, MD. 21 4 0 Approximate Intervel Batween Onset and Deeth SUBARACHNUID MEMMORITAGE Immediate Cause (Final weeks diseese or condition resulting in daeth) Due to (or es e consequence of DISEASE END STAGE RENAL 2 years Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseasa or injury Due to (or es e consequence of): thet initieted events rasulting in deeth) Lest Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes an autopsy completion of cause of daath? 20 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Placa of Daath (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 ANatural 5 ☐ Panding 1 Yes 2 No investigation 2 Accident 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

Examiner ettending physician and for use as the bunal-transit certificate be executed Box 68760. thet the death Division of Vital Records, P.O. the signed by the The law requires peen has certificate Physician: fo the mosphers within 24 hours after death.

To the Funeral Director: After this To the Funeral of the funeral of or Attending

Physician

/Medical

Examiner

10a. Stete

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Funeral

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or frem any injury or other traumatic event, the Medical Exercises

Physician

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Certification:

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25. Wes casa referred to medical examiner? 1 Yes 2 → No 27. Menner of Deeth

4 | Homicida

29a. Certifie

6 Could not be

28f. Location (Street end Number or Rural Routa Number, City or Town, State)

2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, data end plece, and due to the cause(s) end meanar stetad. (Check only 29b. Signatura

29c. License number 12309

29d. Date signed (Month, Day, Year) JANUARY 11, 1999

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

116

SINAT HOSPITAL OF BALTIMORE, GREENSPRING AVENUE, BAUTIMORE BUNTEL, M.O MICHITEL E

1 Certifying Physician: To the best of my knowledga, daath occurred at the time, dete end plece, and due to tha ceuse(s) and mennar as stated.

Registrar

31. Data filed (Month, Day, Year) JAN 1 4 1999 32 Registrar's Signeture

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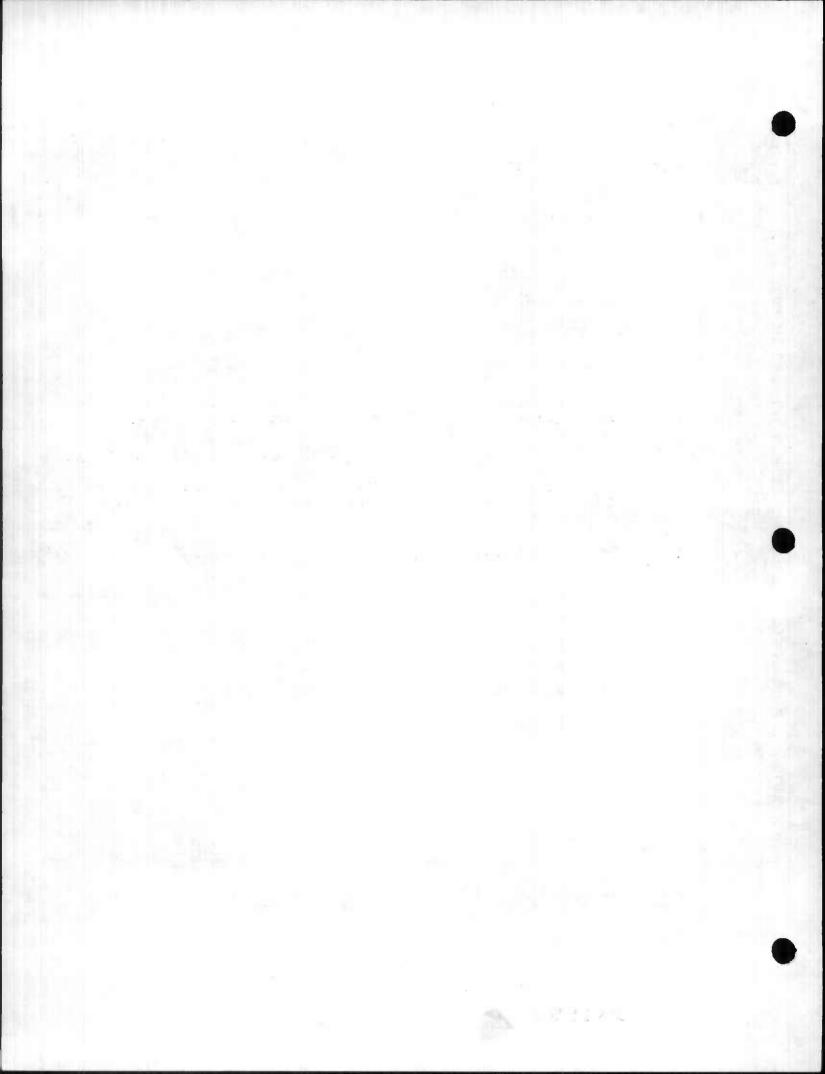
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State of Maryland / Department of Health and Mental Hygiene 99

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Physiciar /Medica	Defilite Lar		on			W		2. Date of Month		ay	Year 99	3. Time o	Death M
Examine	do Contito Namo /M and Institution		er) Age (In yrs. I	lest hirthday)	If Under		Severr	wn, or Location of Dark 24 Hrs. 8, Date of			of Death Arur		or Foreign
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00-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (5		te ce	lece of Dispo emetery, cren len Ha	netory or o	other plec	1.	Jan 1	5		City or Tow urnie		
permit. Page Department of Important: If eny injury or page.	21. Signature of uneral Septice	Licepena		Ba	rrand	\$ 05		P.A. See Hwy., S					
ficete be physicia is the bur	Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulm Due to (or as a consequence of):							avy	Pis	eese	>	10y	
the death cert y the attending sched for use	Part II. Other eignificant condition	d	but not resu	liting in the u	nderlying o	cause give	en in Pert I.	. 23b.	Did tobacc	o use co 2 No	ntribute to		
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Physician: The law require this certificate has been significate has been significate, paga 2 should in Tro Be Completed.							-	of Death (Check of		No	ייי	Yes 2	l No
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deat deat	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At ho etc. (Specify	me, farm, str			165 201	28f. Locati	ocation (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or a within 24 hours aftar within 24 hours aftar completely filled in a Medical Certi	29a. Certifier 1 Certifyir	g Physician: To the be Examiner: On the basis and manner	of examinati										s)
To the within To the compl	29b. Signature and title of certifie	- /		Mh			o number	04		_	d (Month, D		
	30. Name and address of person		death (Item	23a) (Type,	Print)	Rich	sely	te A	קארות	dis	Md à	2140	/
State Registrar	1001 12		strar's Signat	ture 4	1	1	,		J				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year 5:45am PHYLLIS Y. WILEY 0 99 4c. County of Deeth 4b. City, Town, or Location of Deeth 4e Facility Neme (If not institution, give street and number) 8005 BRIDGE POINT DR. CHESTER QUEEN ANNE If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Sociel Security Number Birthpiece (Steta or Foreign Country) 7. Age (In yrs. lest birthdey) 10 M 20F Months Hours Yrs. 53 218-42-2321 OCT. 18 1945 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Vas 2 □ No MARYLAND QUEEN ANNE CHESTER 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 8005 BRIDGE POINT DRIVE 21619 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Amad Forces? 1 Never Married 2 Married I ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Yas 2 € No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOME HEALTH AIDE HOSPIC 18. Mother's Name (First, Middle, Meiden Surneme) 11th 0 HOSPICE 17. Fether's Neme (First, Middle, Last) ALBERT BROWN CHARLOTTE JONES 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) DALE CULLY (SON) 622 WYETH ST. BALTIMORE, MD. 21230 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) HILL CREST CEMETERY 1/15/99 ANNAPOLIS, MD. 21. Signature of Funeral Servica Licenses 22. Name end Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the dissesse, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, App shock, or heart failure. List only one cause on each line. Approximate Interval Betwean Onsat and Daath 5 YEARS LUNG CANCER Immediate Ceuse (Fine) diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undarlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert It. Other etanificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 No 26. Place of Deeth (Check only one) Other: 4□ Nursing Homa 5 Residence 6 □ Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. tnjury et Work? 5 Pending 1 ☐ Yas 2 ☐ No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner physician end s the buriel-transit The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 88 for use es ed by the deteched signed by t d be detect should l nis certificete hes b I director, page 2 s the Hospital or Attending Physician: After this funeral dir death. Director: / within 24 hours effer To the Funeral Direc completely filled in by

Physician

Funeral

Director

should be filed within 72 hours efter death with the Maryland of Mental Hygiene.

marked other than "natural; or frems 23s or 28s-f show umatic event, us Medical Examiner must be notified at

. Peges 1 and 2 should be fill ment of Health end Mental Hant; if item 27 is marked oth jury or other traumatic event

permit. Pege Depertment of Important: If any injury or pnce.

Physician /Medical

Baltimore, Maryland 21215-0020

/Medical

Directo

Funerai

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Certification:

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25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth Neturel 2 Accidant 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 4 Homlcide

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29c. Licanse number

29d. Date signed (Month, Day, Year)

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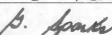
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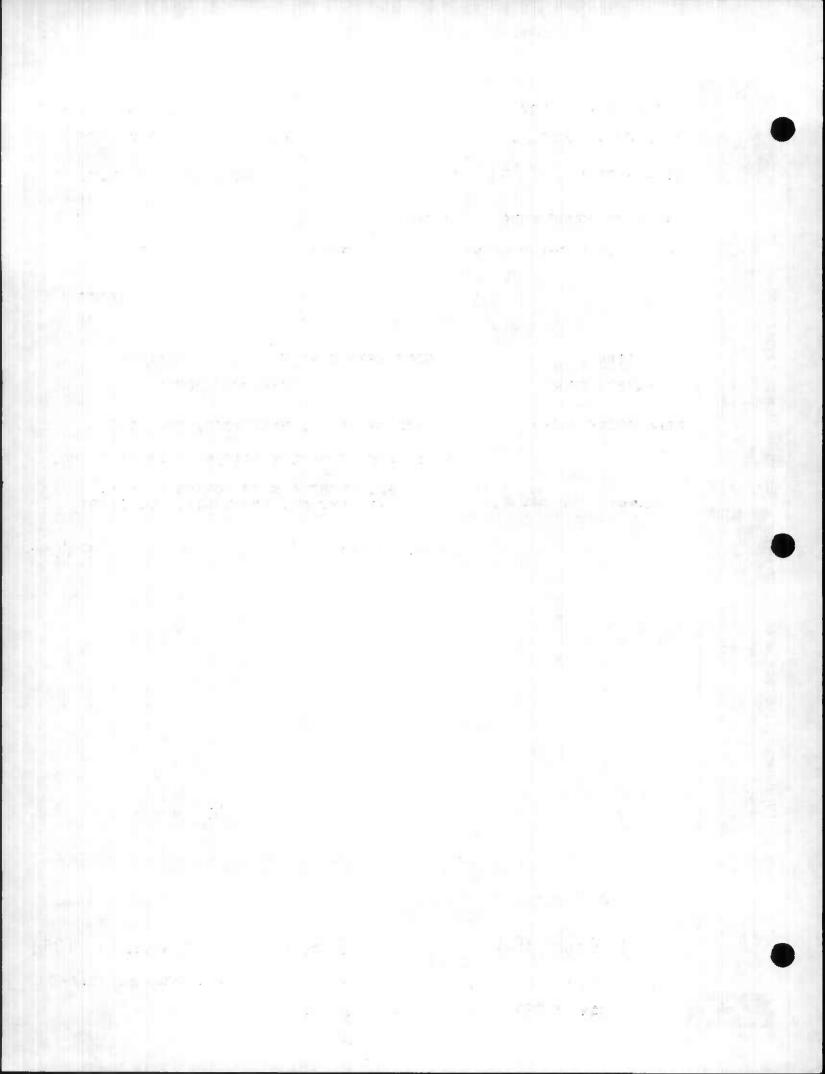
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

STREET BALTIMORE MARYLAND 21287 PAULCORN 600 NORTH WOLFE 31. Dete filed (Month, Day, Year)

State Registrar

32. Registrer's Signeture JAN 1 5 1999





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Desth Year 9, JANUARY 1999 12:20 AM WOODY **EVELYN** 4b. Cify, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street end number) 107 SOUTH BEND ROAD GLEN BURNIE ANNE ARUNDEL If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) If Under 1 Year 5. Sociei Security Number 7. Age (In vrs. lest birthday) Months Deys 1 □ M 2 1 F 67 AUG. 16,1931 MARYLAND 212-28-9465 Usuel Residence of Decedent 10a State 10c City Town or Location 10d. Inside Cltv Limits 10h County 1 ☐ Yes 2 No MARYLAND ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 107 SOUTH BEND ROAD 21060 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11. Maritel Stetus 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced WHITE Year or Dates: Decedent's Usual Occupation
 (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CLERK 11 PHARMACY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CLARENCE HAMPTON RUTH WILKINSON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 SOUTH BEND ROAD, GLEN BURNIE, MARYLAND 21060 KIMBRA A. MARSH (DAUGHTER) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEMORIAL PARK 1/13/99 GLEN BURNIE, MARYLAND 22. Name end Address of Fecility SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061 cations that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death rousnall cell ling cancer Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if sny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): that initiated events resulting in death) Lest Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings svelleble prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation

Physician /Medicai Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or itams 23a or 28a-f ahow the Medical Examiner must be notified at

of filed within 72 hours after death in Hygiene.

Pages 1 and 2 should be not of Health and Mental

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of Health an

important: h any injury o once.

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records,

or Attanding Physician:

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physician and s the bunal-transit as attending esn by tha a 6 been si certificate has t director, page 2 s director. funeral After death.

Physician/Medical Examiner Director: /

g Completed Be Certification: To

Medical

25. Was cese referred to medicel examiner? 1 Yes 2 No 27. Menner of Deeth 1 DNaturel

2 Accident 6 Could not be determined 3 Suiclde 4 ☐ HomicIde

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 12 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier

29a. Certifier

(Check only one)

29c. License number

29d. Date signed (Month, Dey, Year)

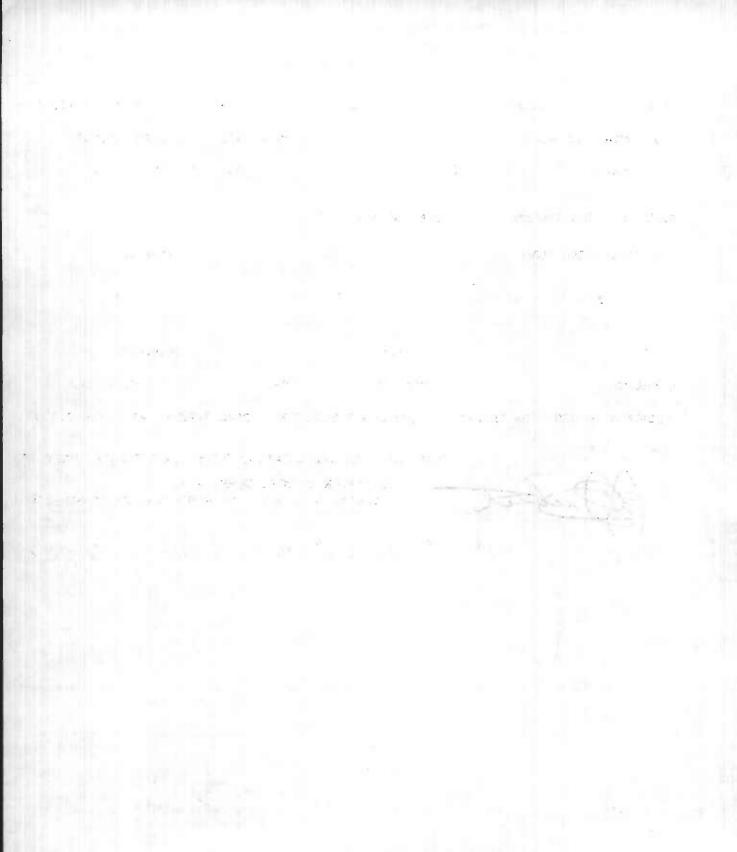
lenge 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Berkman no Horsorview W

31. Dete filed (Month, Dey, Year) JAN 1 3 1999

32. Registrar's Signature

State Registrar

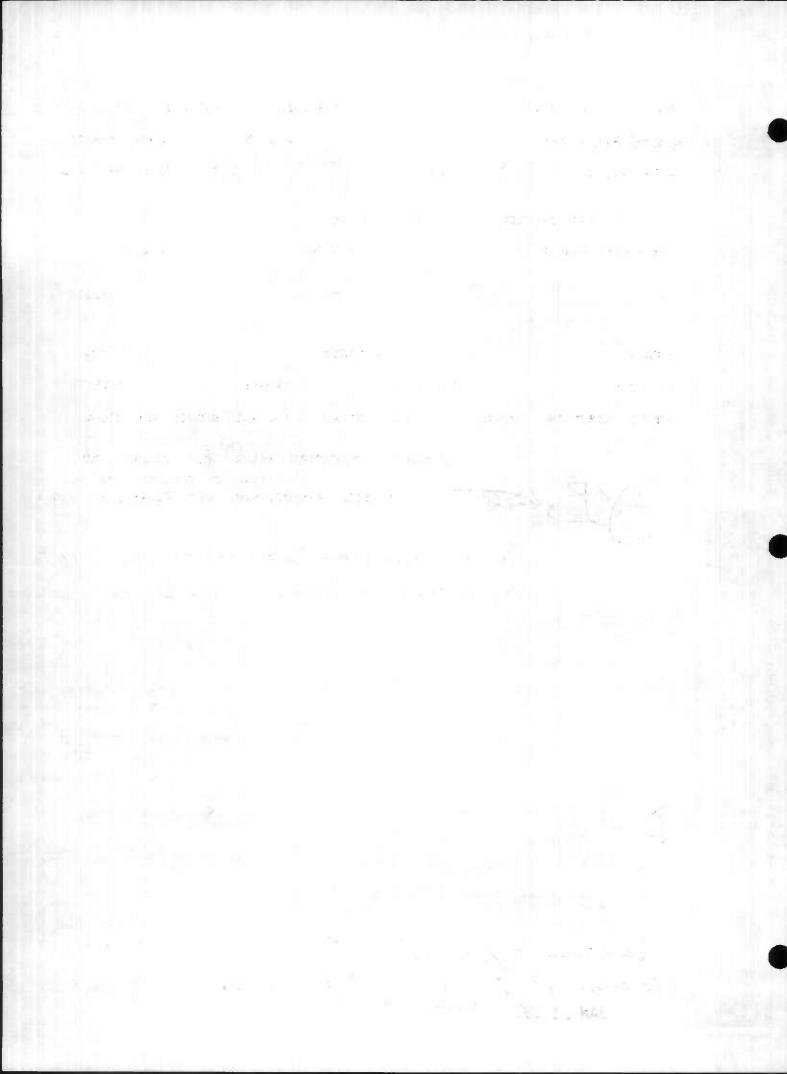
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

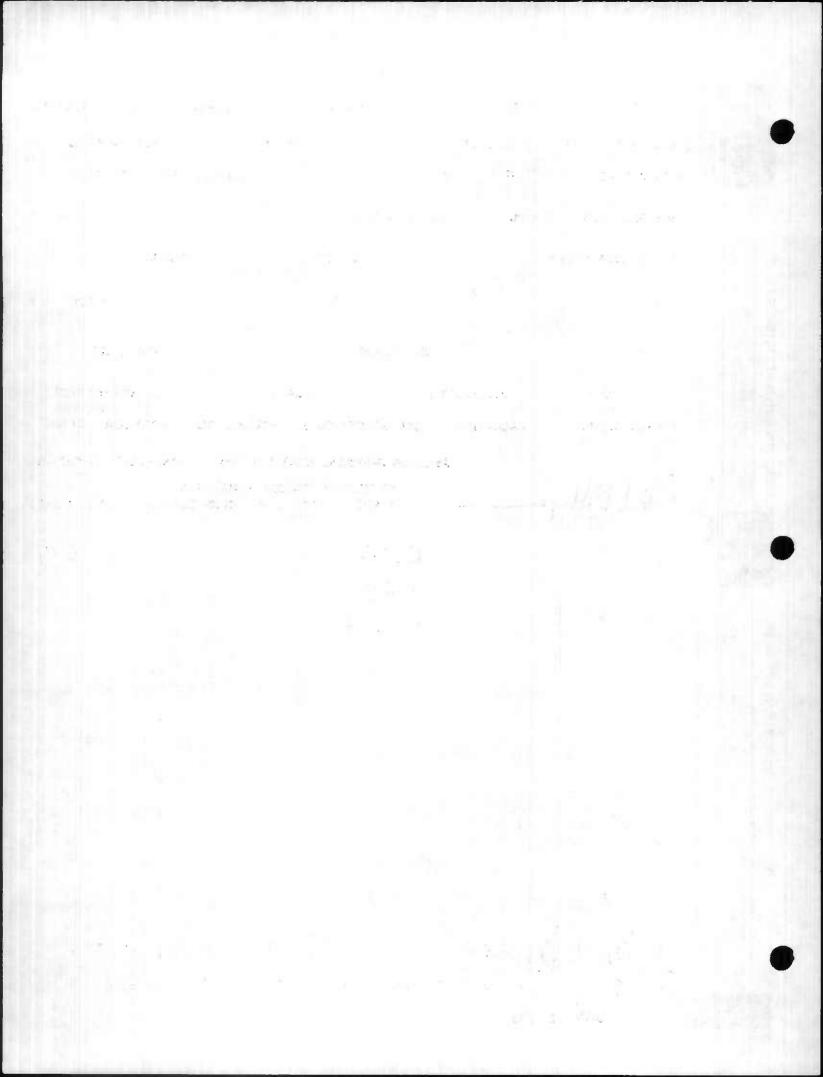
State of Maryland / Department of Health and Mental Hygie	ne
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			Ce	ertifica	e of	Death		Reg	. No.			
	1. Decedent's Name (First, Middle, Last)	Fr(8) = 1					2. Date of Deeth	Day	Vonc	3. Time	of Deeth
Physician	MAE VIRGIN	IA			WIE	ECHMAN		JANUARY	7, 19	Year 99	10	06
/Medical Examiner	4a Facility Name (If not institution, give	street and number)			-		vn, or Lo	cation of Death	4c. County			
	113 HIGHLAND ROAD							URNIE	ANNE	ARUN		
al or	218-30-1144	X 7. Age (in)	vrs. last birthdey 83 Yrs.	Months	Days	Hours		8. Date of Birth (Month, Dey, 1) APRIL 2,	1915	Count	ace (State (ry) LAND	e or Foreign
70	Usual Residence of Decedent 10a. Stete 10b. County		City, Town or L							10		City Limits
ect	MARYLAND ANNE AR	UNDEL	GLEN	BURN	Code			100	. Citizen of V	What Coun		- A
Funeral Director	113 HIGHLAND ROAD	210	060		10,	U.S.	Α.					
by	11. Maritel Status 1 Never Merried 2 Merried **O Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2XXNo if Yes, Give Yeer or Dates:	n U,S. 13	Was Dece If Yes, spe 1 Yes	cify Cub	dispenic Orig en, Mexican, Specify:	gin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)		e - America ck, White, e : Wh		
eted	15. Decedent's Edu (Specify only highest gred			edent's Usu		oatlon during most	of worki		6b. Kind of B	usiness/Ind	lustry	
Completed	Elementary/Secondary (0-12) UNKNOWN	College (1-4or 5+)	life.	DO NOT L	se retire	d)			OW	N HON	1E	
BeC	17. Father's Name (First, Middle, Last)					18. Mother	r's Name	(First, Middle, Ma	aiden Sumen	ne)		
ToB	(UNKNOWN)	S	CANSBURY	7		RA	CHAE	CL		(UNK)	(NWO	
	19a. Informant's Name/Relationship (7)	(SON)							or, City or Town, State, Zip Code) NIE, MD. 21060			
	20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	b. Plece of Disp cemetery, co	emetory or	other ple			/9/99	CHEST	City or To		
	21. Signature of Funeral Service Licens 23a. Part1. Enternal disease, or comp	lications that caused the c	1	SECO	ND A	AVENUE	, s.	W., GLEN	BURNI		-	_
leted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	o (or as a conse o (or as a conse o (or es a conse	equence or)		ndiov	1450	cular	Dise	ASE		
icia	Pert II. Other significant conditions con	ntributing to death but not	resulting in the	underlying	cause oi	ause given in Part I. 2			23b. Did tobacco use contribute to the cause of death?			
y Physician								1 ☐ Yes 2 No 3 ☐ Probably				
Completed by								24a. Was an autopsy performed? 24b. Were autopsy evailable completic of death?		ailable prid apletion of	or to	
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Be	25. Was case referred to medical examiner?					26. Plece	of Death	(Check only one)			
To	12 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatio	ent 3 D	OA Oth	her: 4 Nui	rsing Ho	me 5 Resider	ice 6 🗆 Oth	er (Specify	1)	
ation:	27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Dey Yee	28b. Time Injury	of M	28c. Inju Wo 1 □	ryat rk?]Yes 2 □ h		28d. Describe hov	v Injury occur	red		
Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Stre City or Town,		per or Rure	l Route N	lumber,
edical (sician: To the best of my ner: On the basis of exam and manner stated.										e(s)
Me	29b. Signature and title of certifier			29	c. Licen:	se number		29	d. Date signe	d (Month,	Day, Year	7)
	Millian	Refo	mo		D	060	05.	4	1-8	-90	7	
	30. Name and address of person who co	ompleted cause of death (Print)	59.	5 ×	7m	erica	. 3	103	5 5	
State	31. Date filed (Month, Dey, Year)	32. Registrar's S	1	4	1	1						



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			Cer	tificate of l	Death	1	Reg. No.		
sician	Decedent's Neme (First, Middle, L.					2. Date of De Month	Day Day	Year	3. Time of Death
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miner	4a Facility Neme (If not institution, g			4	b. City, Town, or Lo				
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	Usuel Residence of Decedent					UAN U,	1505	1 1111	JAN D
	10a. Stete 10b. County		City, Town or Loc					10	Od. Inside City Limit:
ral Director	MARYLAND ANNE AR	UNDEL	4ILLERSV	/1LLE					1 □ Yes 2 □ • N
Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
Funeral	306 GALENA COURT		116 140 11	21108		anife Van en Ale	U.S.A.	a - Americ	an Indian
, un	11. Marital Status 1 □ Never Married 2 □ Married	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No	0,3. 13. Y	Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Blac	k, White,	
by	3 ◯ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	I□Yes 21XNo	Specify:		Specify	WH	HITE
	15. Decedent's I		16a. Deced	lent's Usuei Occup	ation		16b. Kind of Bu	isiness/înc	lustry
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0	JOHN AHO	OLLIKAINI			HULDA				AINEN
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SUCE	2 Steparture of Epineral Service Lice	insee		Name end Addres	FUNERAL I	HOME, P	.A.		
	That WHag	an	1	SECOND A	VE. S.W.	GLEN	BURNIE,	MARYI	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3 Time of Death Month Mary Madeline Zajkowski January 14, 1999 2:30 PM 4a. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester General Hospital Cambridge Dorchester If Under 1 Yeer
Months Deys If Undar 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 1 M 2 F Deys Hours 166-18-1338 Nov 10, 1919 Pennsylvania Usual Rasidance of Dacedant 10e. State 10b. County 10c, City, Town or Location 10d. Insida City Limits Dorchester Maryland Taylors Island 1 Yes 20 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4112 Bayshore Road 21669 US 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ĀM No If Yes, Giva Yaer or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11. Merital Status 1 Navar Married 2 Merried 1 ☐ Yes XX No Specify: White Specify: ¥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Stanley Nabozny Katherine (Unknown) 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore M. Nabozny Brother P.O. Box 94 Taylors Island, Maryland 21669 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Ramoval from State Limerick Garden of Memories 1/18/99 Limerick, PA 5 Other (Specify) 21. Signature neral Service Coensee 22. Nama and Addrass of Fecility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shody or heart feilure. List only one cause on each line. Approximeta Intarval Between Onset and Death Immediata Causa (Final dal disaasa or condition rasulting in death) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 Probably 4 ☐ Unknown ellow rasen 24b. Wara sutopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yas 2 100 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Department of Health and Mental important: If item 27 is marked or any injury or other traumatic ev

Saltimore,

P.O. Box 68760,

Records,

Division of Vital

Physician

/Medical

Examiner

Director

Funerai

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Completed

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Funeral

Director

7 is marked other than "natural", or liems 23s or 28s-f shor traumetic event, the Medical Examiner, must be notified at

Examiner the burial-transit Physician/Medicai à Completed Be 2 Certification:

pue be exec physician 88 for usa as ate has been signed by page 2 should be detac The lew requires certificate has After this Attending death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi In by the

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was casa referred to medical 1 Yes 2 No 27. Mannar of Death 1 Inatural 28a. Date of Injury (Month, Dey Year) 28b. Tima of Injury 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 ☐ Homleida Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certiflat

State Registrar

Medicai

31. Data filed (Month, Day, Year) JAN 15 1999

29b. Signetura and title the same

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

Homes Nawa 3 125 August Nawa? 32. Registrar's Signatura

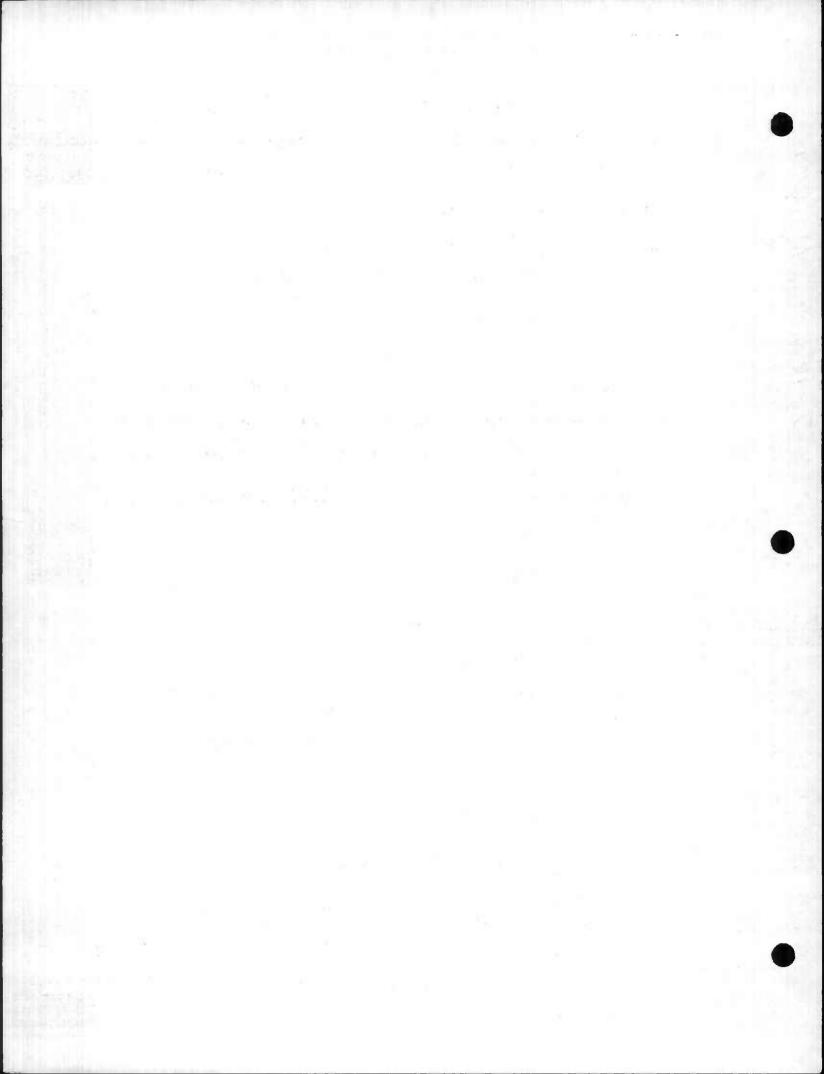
and manner steted.

29c, Licensa number

D0050987

sweet camposidge

29d. Dete signed (Month, Dey, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 6:12AM 1999 Elden Adderly 20 January Pation of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Locat 4c. County of Death Talbot The Memorial Hospital Easton If Under 24 Hrs Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1₩ M 2□ F Months 78 July 16, 1920 572-31-4548 Bahamas Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 610 Dutchmans Lane 21601 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? UNKNOWN 1 □ Yes. 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status unknown Black, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes X□ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) unknown unknown 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) unknown unknown 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) n state 21. Signature of Funeral Service Licensee Joseph 22 State Anatomy Board, 655 W. Baltimore Street Van Sant Baltimore, Maryland 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardrae arrest Immediate Cause (Final disease or condition resulting in death) therasclerosis Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Wunknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy 1 ☐ Yes X No 1 Yes 2 No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes ≥ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

physician end the burial-transit that the deeth certificate be axecuted Box 68760 for use as signed by the a Division of Vital Records, P.O. The law requires been si should ils certificata has director, page 2: al or Attanding Physician: T s after deeth. Il Director: Attar this certificat ed in by the funaral director, p

Physician

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Haalth and Mantal Hygiane. Important: If Itam 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Example from the profit of the contraction.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Physician/Medical þ Completed Be 2 Certification:

Medical

29a. Certifier (Check only one)

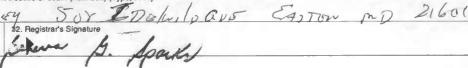
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. License number

29d. Date signed (Month, Day, Year)

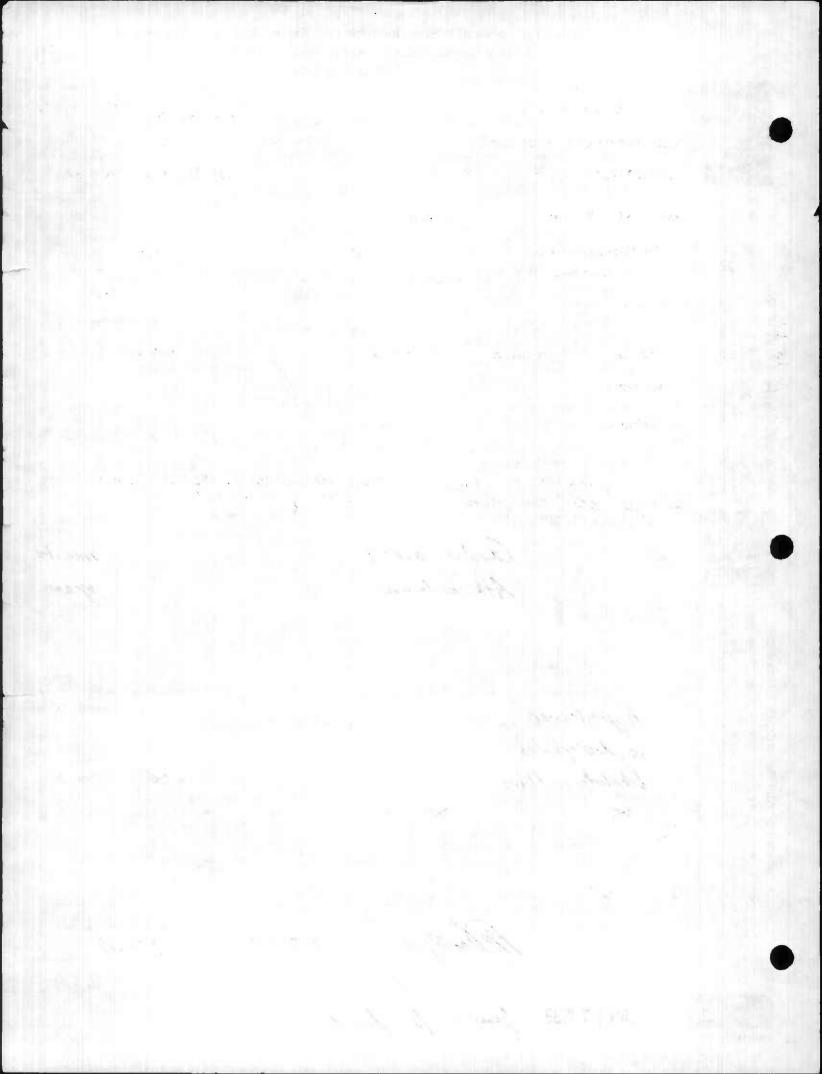
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Sor MICHAEL (Row!

31. Date filed (Month, Day, Year) JAN 27 1999



State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death **Physician** January 23, 1999 820 Ronald J. D Agostino Sr. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 2113 Sunnythorn Rd. Middle River Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth Birthpleca (State or Foraign Country) **Funeral** 1 M 2□ F Months Deys Hours 219 28 8137 66 Yrs. Director Oct. 2, 1932 Maryland Usuel Residence of Deceden the Marylend 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Maryland Middle River permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Ma Department of Health end Menlel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f a any injury or other traumatic svent, in a Medical Expriner must be notified once. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2113 Sunnythorn Rd. 21220 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 XYas 2 No
If Yes, Giva
Yeer or Dates: Korean 1 Never Married 2 Married 1 Yes 2X No Specify: White Specify: p 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Maintenance Aerospace 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fathar's Name (First, Middle, Last) Unknown Unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Ronald J. D Agostino Jr. (Son) 302 Garnett Rd. Joppatown, Md. 21085 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removel from State Greenmount Crematory 1/26/1999 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundual Service Licens 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, bock, or heart feilure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in deeth) Examiner Due to (or es a consequença of Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or es a consequença of): certificete be exe physicien the buria Physician/Medicai thet initieted events rasulting in death) Last Due to (or as a consequence of): 88 950 Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by mone depression 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director. 25. Was casa referred to medical axaminar? Be 26. Place of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Yes 2□ No 10 1 Inpatient 2 ER/Outpetient 3 DOA this 28d. Dascribe how injury occurred

Self - m du funerel 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After 1820 1 Natural 5 | Pending - mauce s efter death. 1-23-99 2 Accident
3 Suicide 1 ☐ Yes 2 No Investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide Duilding, etc. (Specify)

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2113 Summyllion Rd., Balto Md

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner as stated. 21210 Balto Md 24 hours e Hospital 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the ceuse(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number JAN 25, 1999 M.D D076 Organosam

State Registrar

31. Dete filed (Month, Day, Yeer)

間野田 カガニーニ

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

T. CROSCAN O VONOVAN, M.D. 2 112 DUNDALE AVE. 32. Registrar's Signature JAN 27 1999

BALTO MD

DHMH 16 Rev 6/95

altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

Examiner .O. Box 68760, Records, Division of Vital

physician end s the burial-transit that the death certificata be executed USB ö the signed by the s certificata hes b director, paga 2 s Attending Physician: director this funeral After daath. e Hospital or Attendi n 24 hours after death. e Funeral Director: A bletaly filled in by the fi To the Hosp within 24 hou To the Fune completely file

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Examiner

Funeral

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Maryland 21215-0020 HENRY J. ALDERSON

Baltimore,

/Medical

State Registrar

JAN 2

7 1999

29b. Signature and titia of certifiar WM

29c. Licensa number

D14958

29d. Data signed (Month, Day, Year)

JANUARY 21, 1999

30. Name and eddress of person who complated ceusa of death (itam 23a) (Type, Print)

AURORA C. TAN, MD 9600 NORTH POINT ROAD FORT HOWARD, MD 21052

31. Data filad (Month, Day, Year)

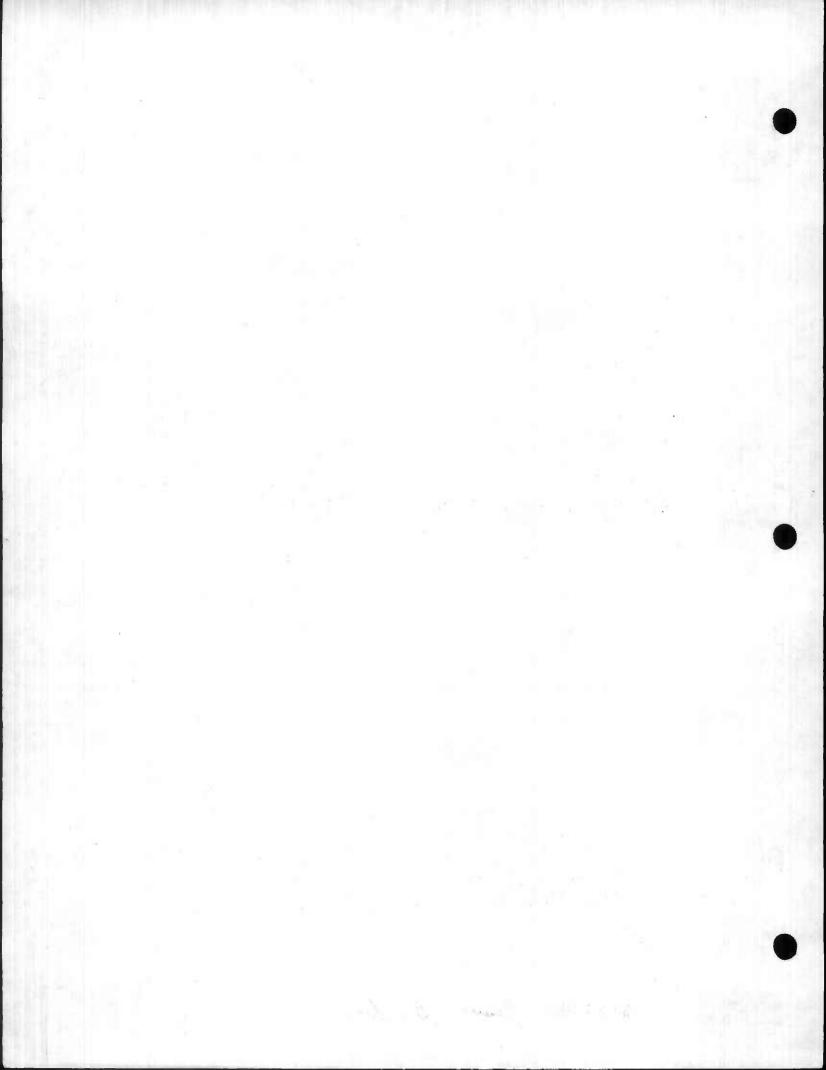
32. Registrar's Signetura

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Ruth Anna Breeden 1999 January 11, 2:40 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 926 South Bouldin Street Baltimore Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Dec. 29, 1915 6. Sex Birthplece (State or Foreign Country) Funeral Hours Months Days 1□ M 2Q F 215-16-5108 83 Director Dec. Maryland Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinet must be notified as once. 1 XYes 2 □ No Director Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 926 South Bouldin Street 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. Specify: White If Yes, Give The Year or Dates: þ 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Waitress Restaurant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Rehberger Margaret Myers 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John McMahon/son 7827 Therfield Road, Sylvania, Ohio 43560 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☑ Donation 5 ☐ Other (Specify) Ronald S 21. Signature of Fugi de Director 22. Name and Address of Fecility Wade State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, hock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onsel and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical myocardial infarction Examiner Physician/Medical Examiner sinus syndrom The law requires that the death certificate be axecuted physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760, pidemia Due to (or es a consequence of): P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2€ No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Be Completed 24a. Wes an autopsy page 2 s certificate has 1 Yes 25 No 1 □ Ves 2 □ No of Vitai Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 SAesidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ephanie 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Linder Stephanie 280/ Foster Baltimore, MD 31. Dete filed (Month, Day, Year) 32, Registrar's Signature State 1999 JAN 27 Registrar



BELL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene

JAMAR

Item 7 Per FH Film G767 1-27-99 rja

Certificate of Death

Physician	
· /Medical	
Examiner	

1. Decedent's Nama (First, Middla, Last) Jamar Gary Bell 2. Data of Death JANUARY 25, 1999

18. Mothar's Nama (First, Middla, Maidan Sumama)

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death

Funeral Director

7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer d. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercises once.

Baltimore, Maryland 21215-0020

Funeral

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death

5. Social Security Number 212-90-6184 Usual Rasidence of Decedani 10a. Stata 10b. County Director

7. Aga (In yrs. last birthday) 10 M 2□ F 21 Yrs. Months 21

10c. City, Town or Location

If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Pay, Year) 08-15-77 Days Hours

 Birthplace (Stata or Foreign Country) MD

MD NA Baltimore 10f. Zip Coda 10d. Insida City Limits X¹√ Yes 2 No

3. Tima of Death

2:35P.M.

10e. Street and Number

21213

10g. Citizen of What Country? USA

1618 East Chase Street

15. Decedent's Educetion

4a Facility Nama (If not institution, giva streat and number)

JOHNS HOPKINS HOSPITAL

12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates:

 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 Yas ZNo Spacify:

14. Race - American Indian. Bleck, White, atc. Black

(Specify only highest grada completed) Flamantary/Secondary (0-12)

3 ☐ Widowed 4 ☐ Divorced

1 Navar Married 2 ☐ Married

College (1-4or 5+)

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired)

16b. Kind of Businass/Industry

11th Grade

Laborer

various trades

17. Fether's Nama (First, Middla, Last)

Ricky R. Bell Denise

Hosley 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) 21213

19a. Informant's Name/Ralationship (Type, Print) Thornton Denise Н.

20a. Method of Disposition

1618 E. Chase Street Baltimore, Maryland 20b. Piece of Disposition (Nama of cametary, crametory or other place)

20c. Location - City or Town, Stata

MBurlal 2 Cramation 3 Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

Baltimore Cemetery 01-30-99 22. Nama and Addrass of Facility

Baltimore, Maryland 21202

Baltimore, MD

Approximate Intervel Batween Onsat and Death

21. Signature of Funeral Sarvice Licensaa Bemond moun

WM.C.March FH 1101E. North Avenue

Physician /Medical **Examiner**

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P.O. Box 68760

Division of Vital Records.

Examiner Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last Physician/Medical

Immediata Causa (Final disaasa or condition rasulting in daath)

Multiple Gunshot Wounds

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Due to (or as a consequence of):

Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

28d. Dascribe how Injury occurred

24b. Wara autopsy findings available prior to completion of ceuse of daath?

10 Yas 2 No

1 Yas 2 No

25. Was cesa referred to medical examiner? examiner r 1 ☑ Yas 2 ☐ No 27. Manner of Death 1 Netural

2 Accidant

3 Suicida

4 Homlcide

Hospital: 1 ☐ Inpatiant 2X ER/Outpatlent 3☐ DOA 5 Panding invastigation 6 Could not be datamined

28a. Data of Injury (Month, Dey Year) 1/25/99

28b. Tima of 1410 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 28c. Injury at Work? 1 Yas 2 No

subject shot

111 Penn Street, Baltimore, Maryland 21201

26. Place of Death (Check only ona)

281. Location (Street and Number or Ryral Routa Number, City or Town, State) 254 E. Monument St. Baltimore, Md

29a. Certifiar (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end place, and dua to tha ceusa(s) and mannar as stated.

2 Medical Examiner: On tha basis of axamination and/or invastigetion, in my opinion, death occurred at tha tima, data and place, and dua to tha causa(s) and manner stated.

29c. License number

29b. Signatura and titla of certifier

street

29d. Data signed (Month, Day, Year) JANUARY 26, 1999

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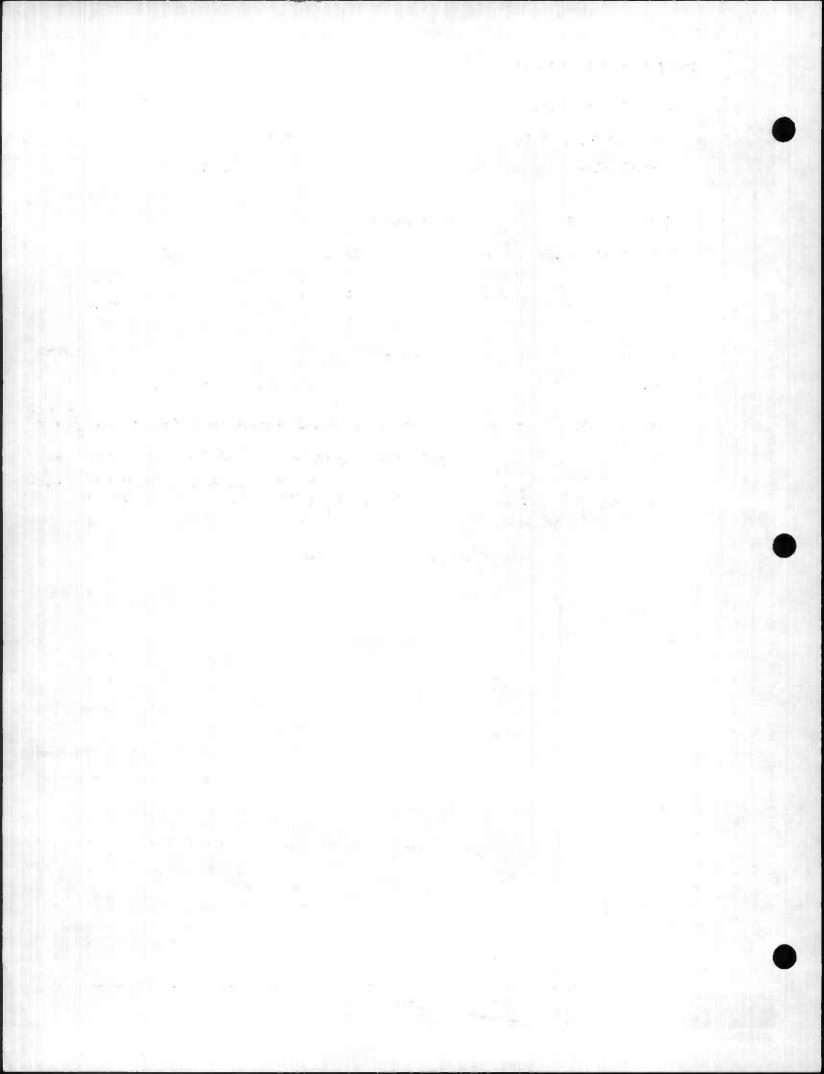
hut m complated ceusa of death (Itam 23a) (Type, Print) 30. Name and address of person who

O.C.M.E.

Registrar

Pennisu 31. Data filed (Month, Day, Year) JAN

Mrs) Registrar's Signature



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Dete of Deeth 1, Decedent's Neme (First, Middle, Last) 3. Time of Death 15 () Wn Dod fow 11:00 Pm 21 City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street and number) Honor 1 Year If Under 24 Hrs. 8. Date of Months Days Mours Anne Arundal Count Medka lunde Hone 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year) 08-24-33 9. Birthplece (State or Foreign West Virginia 7. Age (In yrs. last birthday) 5. Social Security Number Months Deys Hours 234-52-5638 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No Prince George's Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12516 Kilbourne Lane 20715 United States 12. Was Decedent Ever in U,S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Detes: 60-6 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Specify:White 1 ☐ Yes 2 XNo Specify: 60 - 623 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) Coilege (1-4or 5+) 12 Construction Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Woodrow B. Brown Mary Moats 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 12516 Kilbourne Lane Bowie, MD 20715 19a. Informent's Neme/Reletionship (Type, Print) Alicia C. Brown 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 XCremation 3 ☐ Removal from State 1/23/99 Huntt Crematory Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Robert E. Evans Funeral Home, I 16000 Annapolis Road Bowie, MD Inc red plicetions that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) Obar Sequentially list conditions, if any, teeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In deeth) Last Due to (or es e consequence of) Due to (or as e consequence of): roll Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown 06454 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24e. Was en eutopsy 2 No 1 Yes 25. Was cese referred to medicel examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 1 Inpatient 2 ER/Outpatient 3□ DOA Menner of Death 28d. Describe how injury occurred 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 1 Neturet 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier

that the death cartificate be axecuted P.O. Box 68760. Division of Vital Records, or Attending a Funeral Di Funeral Di Hospital To the Hospi within 24 hou To the Fune complately fil

Physician

/Medical

Examiner

Funeral

Director

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7 is marked other than "natural", or items 23s or traumatic event, the Magical Examiner must be

permit. Pagas 1 and 2 should be filed within 72 hours aftar death a Department of Health and Mental Hygiane. Important: if itam 27 is marked other than "natural", or items 234 any injury or other traumatic event, the Medical Examiner mans.

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Certification: To

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Baltimore, Maryland 21215-0020

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Registrar

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nomas 31. Date fited (Month, Dey, Year) JAN 27

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30. Name end eddress of person wh

29b. Signeture and title of certifler

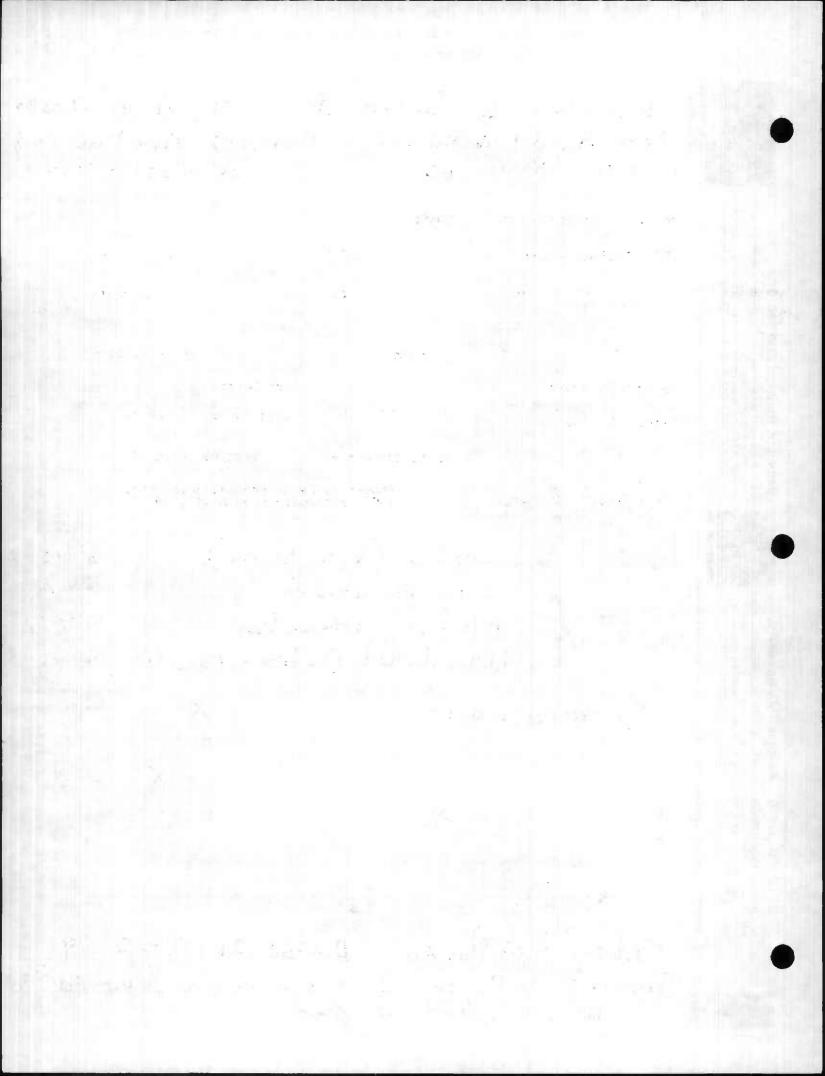
32. Registrar's Signature

e of deeth (Item 23e) (Type, Print)

perior lone Bavie

29c. License number

29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month RODE 75, 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death RANDALLSTOWN BALTIMORE Northwest HOSPITAL 6. Sex 1 M 2 F If Undar 1 Year if Under 24 Hrs. 8. Data of Birth Hours Min. (Month, Dey, 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiaca (Stete or Foreign Country) Months Days 218-32-5841 64 Yrs. Oct. 31, 1934 BALTIMORE CO. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? CLIFTON AVENUE U.S.A. 5421 21207 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 12 Never Married 2 ☐ Married 1 Yes 2 No If Yas, Give Year or Datas: 1 Yas 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 1 Mc Donough School Kitchen Help 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumema) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Charles DANIEL Smith Fulton AVENUE Baltimore Maryland 21216 (SON) 20b. Placa of Disposition (Name of cemetery, cremetory or other place) Metro Date 20a. Method of Disposition 20c. Location - City or Town, State Jan, 27. 99 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Voshells Crematory JAN 28 199 BALtimore 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility RONALD A. GRAYSON FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart tailure. List only one cause on each line. 8312 LIBERTY ROAD BALTIMORE COUNTY 21244 Approximata interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of):

Physician /Medicai Examiner

permit. Page Department of Important: If any Injury or once. Injury or

Physician

/Medical

Examiner

10a. State

Director

Funeral

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death with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or itema 23a or 28a-f show Lry or other traumatic svent, the Medical Examinat must be nouned.

Baltimore, Maryland 21215-0020

Examiner physician and the burial-transit Physician/Medical 88 980 o been signed by the a should be detached t by Completed page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, s Be 2

Certification:

disaase or condition resulting in death) hehmou hic Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yss 2 No 3 Probably 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 1 No 1 ☐ Yas 2 ☐ No 25. Was case reterred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 hipatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Naturai 5 Pending 1 Yes 2 No 2 Accidant investigation 6 Could not be determined 3 Suicida 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year)

Randallston

Division of Vital Records, P.O. Box 68760,

law requires that the death certificate be

this certificate has

State Registrar

Medical

29b. Signature end title of certifier

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31. Date files Anthopan Yes 99

30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print)

2. Registrer's Signature

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The law requires that the deeth certificate be executed P.O. Box 68760 Division of Vital Records, or Attending Physician:

Baltimore, Maryland 21215-0020

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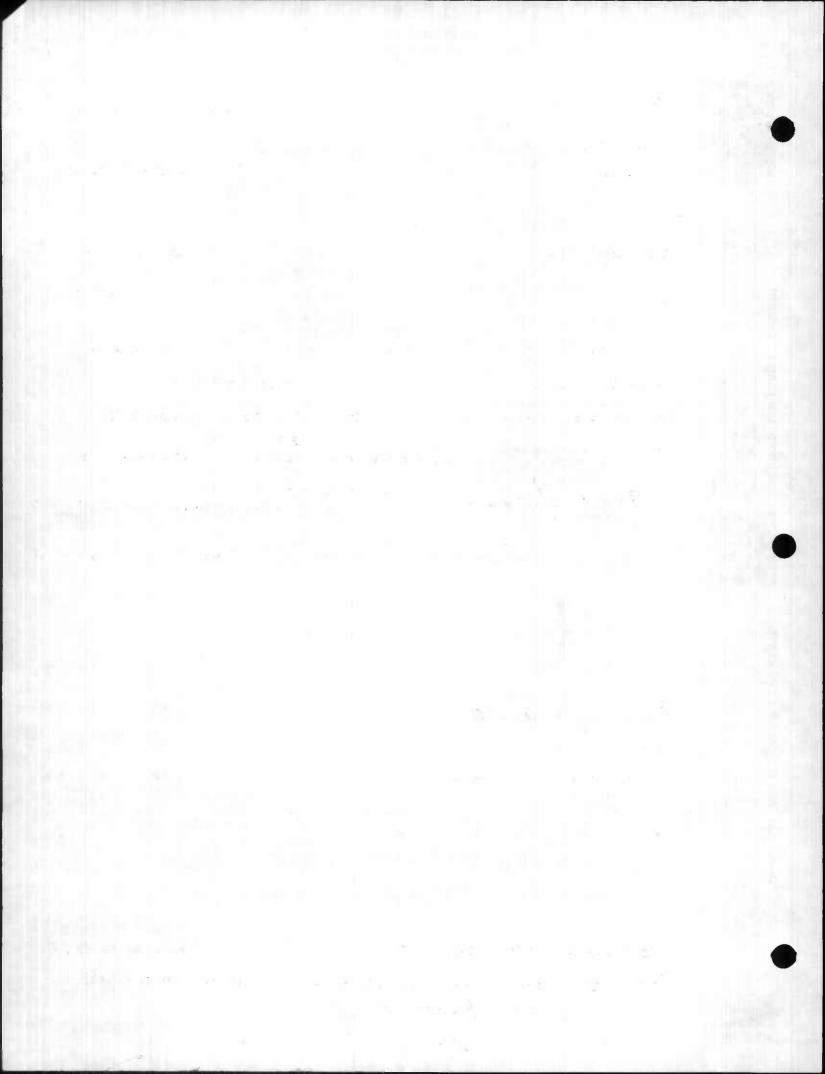
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DEVORE MD 4203 QUEENSAURY Rd HYATTSVILLE, MD 20781 32. Registrer's Signatura JAN 27 1999

30. Name and addrass of person who complated cause of death (Itam 23a) (Type, Print)

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 1999 ANDREW 25 CASEY JANUARY JOHN 6:30AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 7. Age (In yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Months Days Hours 13M 20F Yrs. Director 186-16-5594 FEB. 15, 1922 Usual Residence of Deceden 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "natural", or Nema 23s or 28s-f show other traumatic avant, the Medical Examinat matal be notified at 1 TYas 2 No Director BALTIMORE MD PARKVILLE 10e. Street and Number # 3406 TREVOR PLACE 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21234 Funeral 8810 BLVD. WALTHER Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Merried 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced WWII WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MARYLAND STATE DEPT. Elementery/Secondary (0-12) College (1-4or 5+) OF 12 MONITOR/COUNSELOR PARDLE AND PROBATION permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Nem 27 is marked other any Injury or other traumatic avant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be 2 LAWRENCE J. CASEY BOYLE MARGARET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
#3406 TREVOR PLACE 19a. Informent's Name/Reletionship (Type, Print) 20b. Piece of Disposition (Name of cametery, cremetory or other piece)

FVANS PUNCLAL CHAPEL PARKVILLE, MD. 21234
Dete 20c. Location - City or Town, State GERTRUDE S. CASEY, SPOUSE BLVD 20e. Method of Disposition JAN. 28, 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1999 BELAIR - P.A. FOREST HILL, MD. 22. Name and Address of Fecility EVANS CHAPEL OF MEMORIES 21. Signature of Funeral Service License 8800 HARFORD PD. PARKVILLE, MO. 21234 Perf 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finel Preumonia Aspiration one hour diseese or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner Lung Cancer physician and s the burief-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): be axed 68760 Emphy soma Physician/Medical Due to (or es a consequence of): use as ding Box 23b. Did tobecco use contribute to the cause of death? P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yee 2 No 3 Probably 4 Unknown Records, p 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Was en eutopsy 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case reterred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deatl 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After Attanding 5 Panding investigation 1 Netural Injury death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Cortifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Dev. Year) Ollen 00043489

State Registrar

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31. Dete filed (Month, Dey, Year)

JAN 27 1999

DHMH 16 Rev 6/95

ORIGINAL

GTOI NORTH CHARLES

BALTIMORE, MD.

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

BALTIMORE MEDICAL CENTER

32. Registrer's Signeture

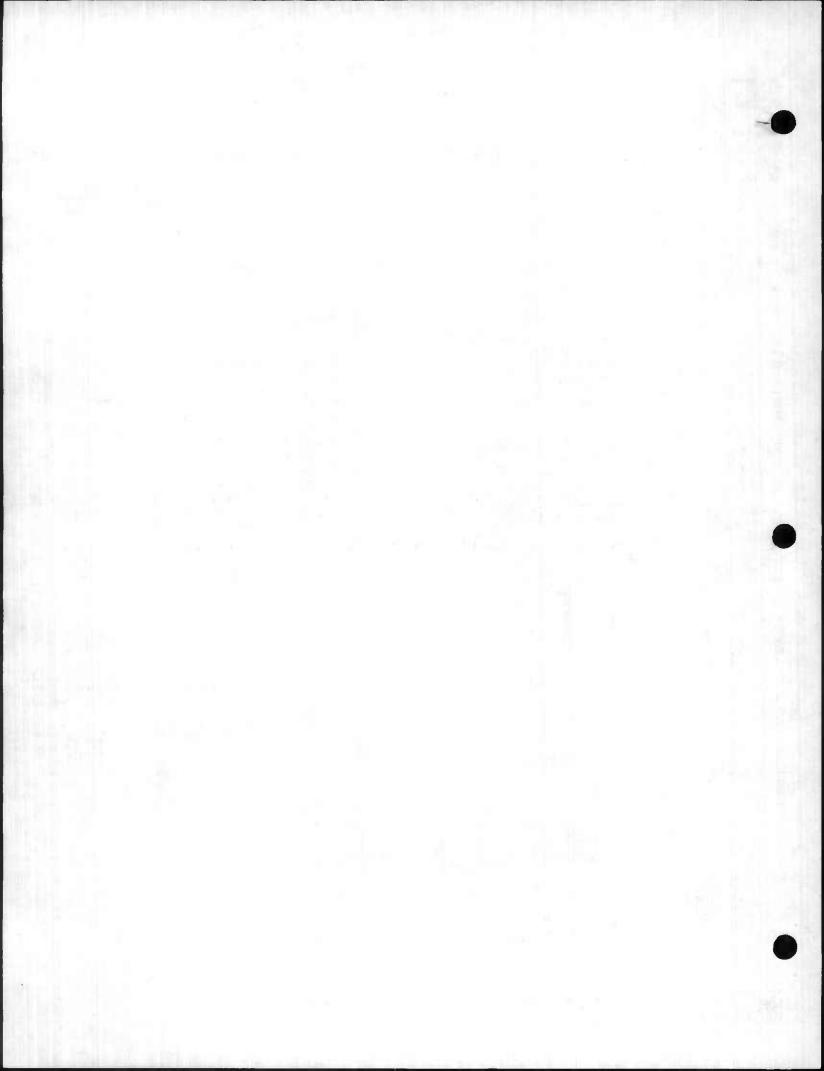
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State of Maryland / Department of Health and Mental Hygiene 9 9 0 | 8 5 9

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	Funeral Director	122 12 5737	6. Sex 7. A	ge (In yrs. last birt 77	hday) If Und Months	er 1 Year Days		8. Data of Birth (Month, Day March 2			ace (Steta or Foreign y) York
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	23a or 28a-f ahow Le notified at ral Director	10e. Street and Number 12211 Malta La			10f. Z	ip Code	20715		Og. Citizen of United		
020	il, or hams	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Amed Forces od 1 ∰ Yas 2 ☐ If Yes, Giva Year or Dates:	?	13. Was Dec		Hispanic Origin? (Sean, Mexican, Puart	pecify Yas or No- o Rican, atc.)	14. Rac Bla Specifi	ce - Amarica ck, Whita, at y: Whi	tc.
121		15. Decedent' (Specify only highest Elementary/Secondery (0-12)	s Education grade completed) College (1-4or	5+)	lifa. DO NOT	rork dona	during most of wor	-	16b. Kind of B United Air For	State	istry S
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Maryland	Health and Mental Health and Mental Health and Mental Health and Mental To Be	19a. Informant's Name/Ralationsh Lorraine A. Con					land Number or Ru Lane Bow			, Stata, Zip (Code)
ore		20a. Mathod of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp					∞) Feb. 3		20c. Location		m, State
Balt	Department of Important: If any Injury or phose.	21. Signature of Funerel Sarvice L	icansee		Rober	t E.	ess of Facility Evans Fu apolis Rd			_	15
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100	/Medical Examiner	Immediata Causa (Finel disease or condition rasulting in deeth)	aH	Dua to (or as a c	consequence of		li od	- Vin		1	y-
68760,	g physician and as the bural-transit	Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated avents	b	Dua to (or as e c	onsequence of):					
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	21/	30. Name and address of person w	no completed cause of class of which were	death (Item 23a) (Type, Print)	odn	napoli	Rd.	anho	mn	ND 20701
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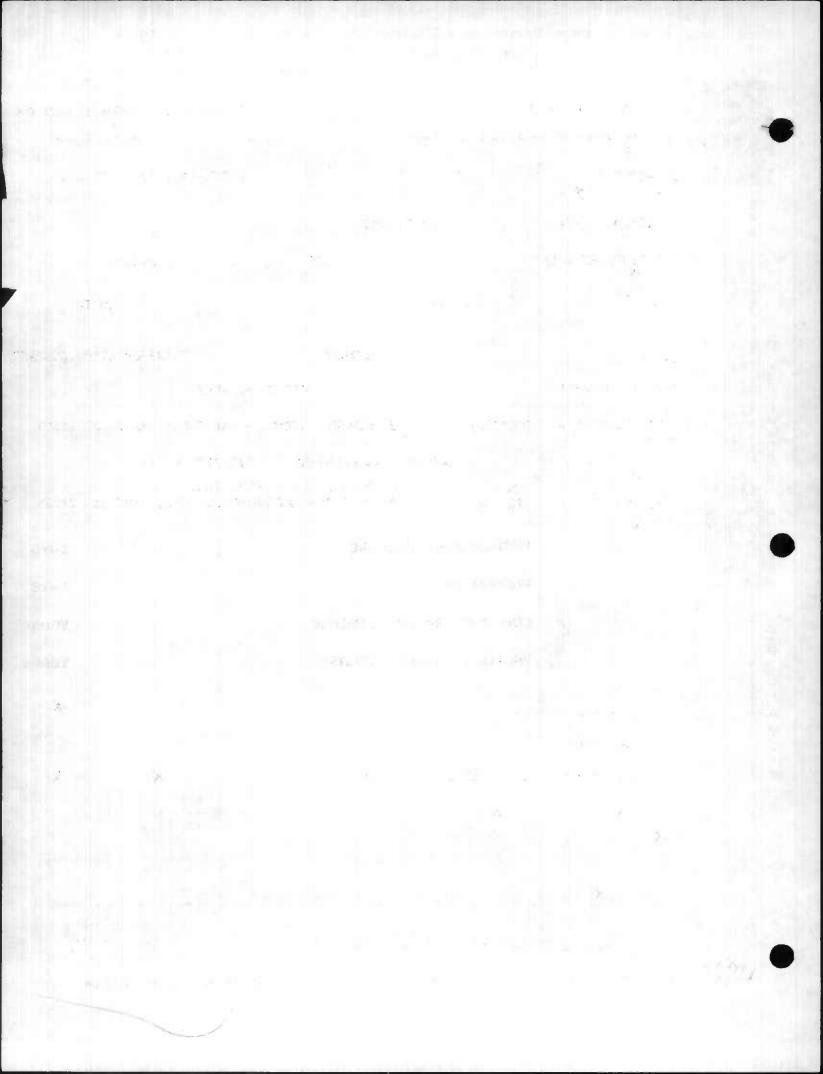
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1. Decedant's Nama (First, Middla, Last) WILLIAM B. CASSELL 4a Facility Nama (If not institution, give street and number) Saint Joseph Medical Center Funeral Director 5. Social Sacurity Number 2. Data of Death Month Day Year 4b. City, Town, or Location of Death Funeral Director 5. Social Sacurity Number 218-05-1554 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 4b. City, Town, or Location of Death TOWSON Baltimor 7. Aga (In yrs. lest birthday) Yrs. Months Days Hours Min. MARCH 14, 1913 MARYLAN Usual Rasidance of Decedant 10a. Stata 10b. County MARYLAND N/A BALTIMORE 10f. Zip Coda 10g. Citizan of What Country? 11. Marital Status 12. Was Decedant Evar in U.S. 13. Was Decedant Corigin? (Specify Yes or No- 14. Race-American India) 14. Race-American India
WILLIAM B. CASSELL 4a Facility Nama (If not institution, give street and number) Saint Joseph Medical Center 5. Social Sacurity Number 6. Sax 1\text{TOWSON} 6. Sax 7. Aga (In yrs. lest birthday) Vrs. 6. Date of Birth (Month, Day, Year) Winder 1 Year 1\text{TOWSON} March 14, 1913 MaryLan MaryLan
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5. Social Sacurity Number 6. Sax 1 Name 2 F 7. Aga (In yrs. lest birthday) 1 Name 2 F 85 7. Aga (In yrs. lest birthday) 1 Name 2 F 85 85 85 9. Birthplaca (State Country) Months Days Hours Min. Months Days Hours Min. MARCH 14, 1913 MARYLAN
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11. Marital Status 12. Was Decedant Evar in U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lif Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Armarican Indian If Yas, specify Cuban, Maxican, Puarto Rican, atc.)
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Elementary/Secondary (0-12) College (1-4or 5+)
7TH GRADE TRANSPORTATION 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Meidan Surnema)
CHARLES CASSELL CATHERINE BURY
19a. informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
EDWIN T. BURLIN (NEPHEW) 1222 WEDDELL AVENUE - BALTIMORE, MARYLAND 2
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21. Signatur of Funaral Sarvice Licensee 22. Nama and Addrass of Facility
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 2
23a Part Lintar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approx Interval
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immediate Causa (Final disassa or condition RESPIRATORY FAILURE
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d VALVULAR HEART DISEASE
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause given in Part I.
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Carcinoma Stomach 23b. Did tobecco use contribute to the cause of
Carcinoma Scomach
Urinary Tract Infection 24a. Was an autopsy performed? 24b. Wara autopsy available p
complation of death?
Chronic Obstructive Pulmonary Disease
25. Was cese rafarred to medicel axaminar?
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27. Mannar of Death 1 Natural 5 Pending 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28b. Tima of Injury 28c. Injury at Work? Work?
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29a. Cartifiar (Check only one)
29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Ya
1-22-99
30. Nama and addrass of person who completed ceusa of daath (Itam 23a) (Type, Print)
FRANCIS T. KHOO, M. D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204
31. Data filad (Month, Day, Year) 32. Registrar's Signatura
JAN 27 1999 Beauty B. Sparks

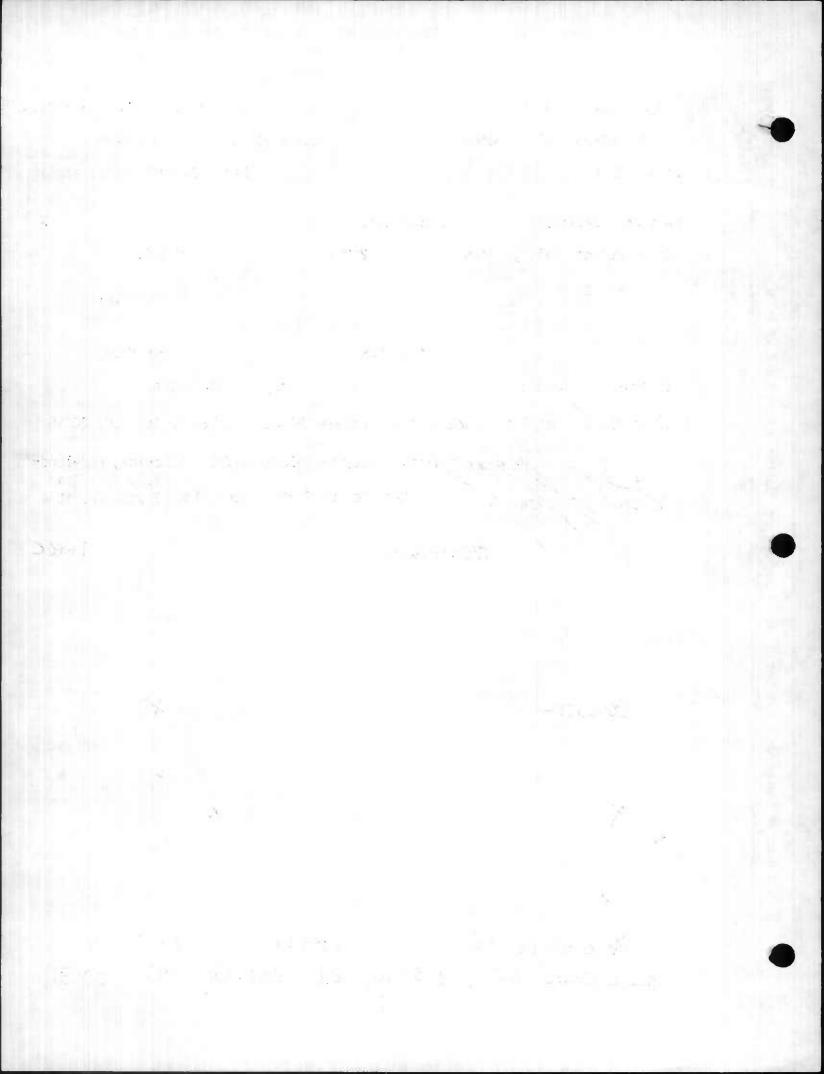
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month **Physician** January 23, 1999 Anna Rita Cataneo 11:50a.m. /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2106 Dulaney Valley Road Lutherville Baltimore If Under 24 Hrs. B. Dete of Birth (Month, Dey, Year)
Hours Min. March 20, 1912

9. Birthplece (State or For Country)
Pennsylvania If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 2 F Months Deys Yrs. 213-05-2778 86 Director Usual Residence of Deceden death with the Maryland 10d. toside City Limits 10a. Stete 10b. County 10c. City. Town or Location v 28a-f show 1 Yes 2 No Directo Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 21093 2106 Dulaney Valley Road U.S.A. Funeral 14. Rece - American Indian, Fages 1 and 2 should be filed within 72 hours efter dea ner of Health and Montal Mygiene. Ittl: If term 77 is marked other than "natural; or items may or other traumatic event, the Modical Evantrice in 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1☐ Yes 2♥ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 8yrs. Home Maker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Bierratta Vincent Barone Mary 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Mrs. Gloria Cataneo Tosi/Daughter 4348 Westover Place N.W. Washington, D.C. 20016 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 4 Donation Souther (Specify) Entombrient Dulaney Valley Mausoleum 1/27/99 Timonium, Maryland 21. Signature of Fundal Service Licenses 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 are that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Intervel Between Onset and Deeth or compact **Physician** /Medical Immediate Cause (Finel I WEEK nemena disease or condition resulting in deeth) Examine Due to (or es e consequence of): Examiner physician and s the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of) attending p for use es 98 signed by the a 23b. Dtd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Domanta 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy performed? completion of cause of death? is certificate has director, page 2 1 Yes 2 No 1 Tyes 2 No Physician: Be 25. Wes case referred to medicat exeminer? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Attending Neturel 5 Pending Investigation 1 Yes 2 No death. ector: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) in 24 hour.
The Funeral Direction by 6 4 T Homicide 6 Hospital Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical To the Hosp within 24 hor To the Fune completaly ti (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature end title of certifier 034521 1-25 -99 Mark amos 30. Neme and eddress of person who completed rouse of deeth (Item 23s) (Type, Brint) Hunt valo W 2 1031 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JAN 27 1999 Registrar



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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year **Physician** abbagestalk 55 23 mm 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Sociel Sacurity Number 30/+ m If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) enter Treuma 6. Sax Boltimore If Under 1 Year 9. Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. Months 150-23-4639 Usual Rasidance of Decedant 1 ■ M 2 1 F Hours Yrs. 1970 New. Director 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yas 2 No Director Vort 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 10032 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Nevar Merried 2 Merried 1□ Yes 2 No specity: Black altimore, Maryland 21215-0020 Specify: à If Yas, Give Yaar or Datas: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Womestic Home maker d 2 should be filed w th and Mental Hygier 7 Is marked other th 17. Fathar's Nama (First Middle Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Donnie Cabbagestalk-Williams Love 19a. Informant's Name/Ralationship (Type, Print) mother 44 W. 156 Th. Street Clizabeth Cabbagestalk Williams 20a Mathod of Disposition 20a Mathod of Disposition Mew York My 10032 20c. Location - City of Town, Stata Pages 1 and 2 nent of Health a 20b. Place of Disposition (Name of Januar 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 22. Nama and Address of Facility Dodgkss Funeral Service 1701 Me Culloh Street, Balt, more, mice 29,1999 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licenses 23a. Part 1. Entar tha disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician /Medical Immediata Causa (Final "Vetary disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of): notor veh: physician and the burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2ENO 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 10 Tas 20 No 10 11 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: After 5 Pending invastigation 9:254 M (Month, Lay) 12 / 1955 9:1/7 Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Attanding 1 Natural after death. 1 Yas 2 No 112 Motor Vehille Crash
281. Location (Street and Number or Rural Routa Number,
City or Town, Stata) Crash 2 Accident 3 ☐ Suicide 6 Could not be datarmined 4 T Homicida ŏ ever Name Hong B159 24 hours a Funeral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar edicai (Check only one) the within To the 29b. Signature end little of certifier 29c. License number 29d. Data signed (Month, Day, Year) ann 30. Nema and addrass of person who completed causa of ceath (Item 23a) (Type, Print) ooper (enter arnell

Registrar **DHMH 16 Rev 6/95**

State

31. Data filed (Month, Day, Year)

JAN 27

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month EGIELSKI 1999 :04pm LORMA anuary 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Legation of Death 4c. County of Death Baltimore Good Samaritan Hospital n/a If Undar 24 Hrs. 7. Aga (In yrs. last birthday) If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) April 10,1921 Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 6. Sax Months Days 1 M 2ELF Hours 213-34-5341 Usual Rasidance of Dacedant 10a. Stata 10d. inslda Cltv Limits 10b. County 10c. City, Town or Location Harford Md. Edgewood 1 ☐ Yas XX No 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1946 Steven Drive 21040 USA Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 11 Marital Status 1 Yas 2 XNo 1 ☐ Navar Married 2 ☐ Married White 1 ☐ Yas 2 ☐XNo Specify: Specify: If Yas, Give Yaar or Datas: 3 Widowed 4 K Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) own home Home maker 11th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) James Laird Virginia Bradnick 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Grace Mercer /daughter Sussex Road Baltimore Md. 21221 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) Holly Hill Cemetery 1/25/99 Baltimore Md. 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221 23a. Pert1. Enter the disease, or or mplications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on your cause on each line. Approximata tntarval Batween Onsat and Daath Immediate Ceuse (Final disaasa or condition rasulting in daath) Due to (or as a consequance of): Sequantially list conditions, if any, laading to Immadiata cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in daath) Last Dua to (or as a consequance of): Dua to (or as a consequance of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Dtd tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings availabla prior to complation of causa of death? 24a. Wes en eutopsy performad? teomy later 2 No 1□ Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only one) Hospital: 1 Denoatiant 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 27. Mannar of Death 28b. Tima of 28d. Dascribe how Injury occurred 1 Diatural 2 Accidant Injury 5 Panding

Examiner Division of Vital Records, P.O. Box 68760. that the death certificate bephysical signed by the a The law requires should should is certificate has to director, page 2 s or Attending Physician: this After this funeral of death. Director: /

Examiner Physician/Medicai þ Completed Be 2 Certification:

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/Medical

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il Hygiane. other than "naturel", or items 23a or 28a-f show vent, the Medical Examiner must be notified at

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parmit. Pages 1 end 2 should be Depertment of Health and Mentel Important: if itsm 27 is marked ony injury or other traumatic event

Physician

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24 hours after Funeral Dire letely filled in b the the within To the 0

Hospital

29b. Signature.

Invastigation

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29c. Licansa number

2 Medical Examinar: On the basis of examinetion end/or investigation, In my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated.

1 🖰 Certifying Physician: To tha best of my knowledga, daeth occurred et tha time, deta end place, end due to the ceuse(s) end menner es stated.

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29d. Date signed (Month, Day, Year)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta)

ss of person who complated causa of death (Itam 23a) (Type, Print)

Baltimore 560 Blood, SKAF ICHEL Zoch 31. Data filed (Month, Day, Year)

State Registrar

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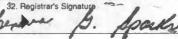
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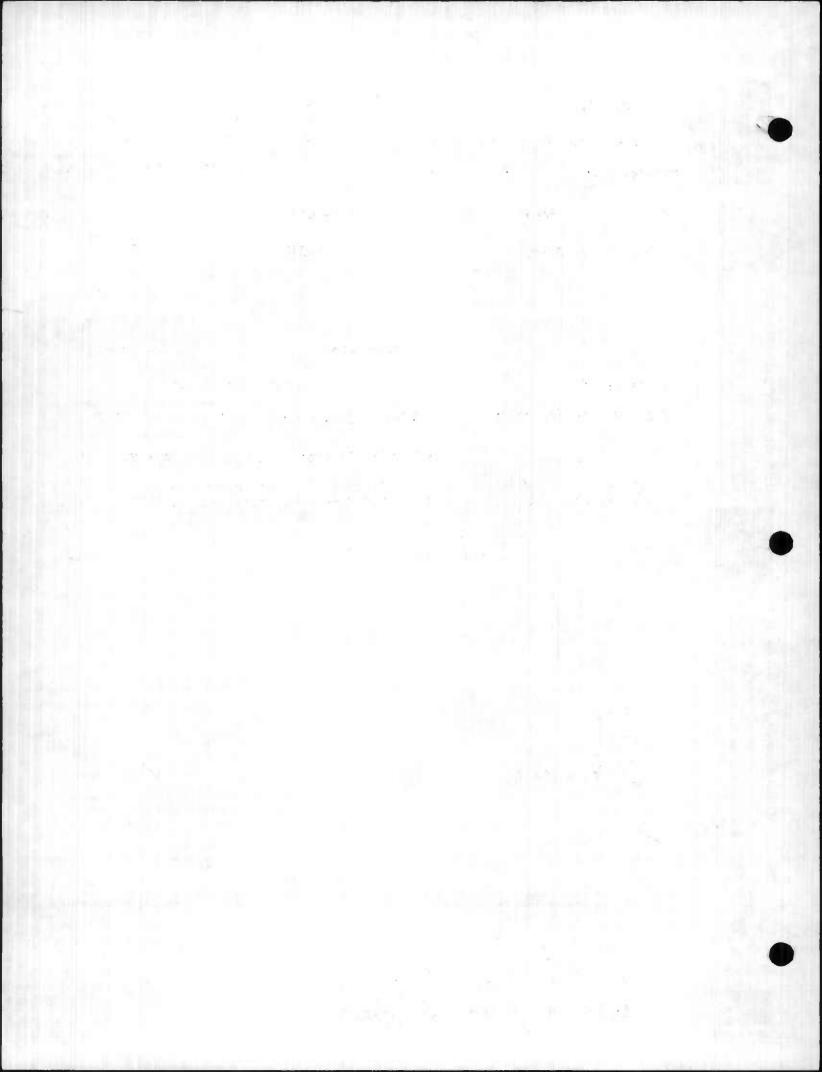
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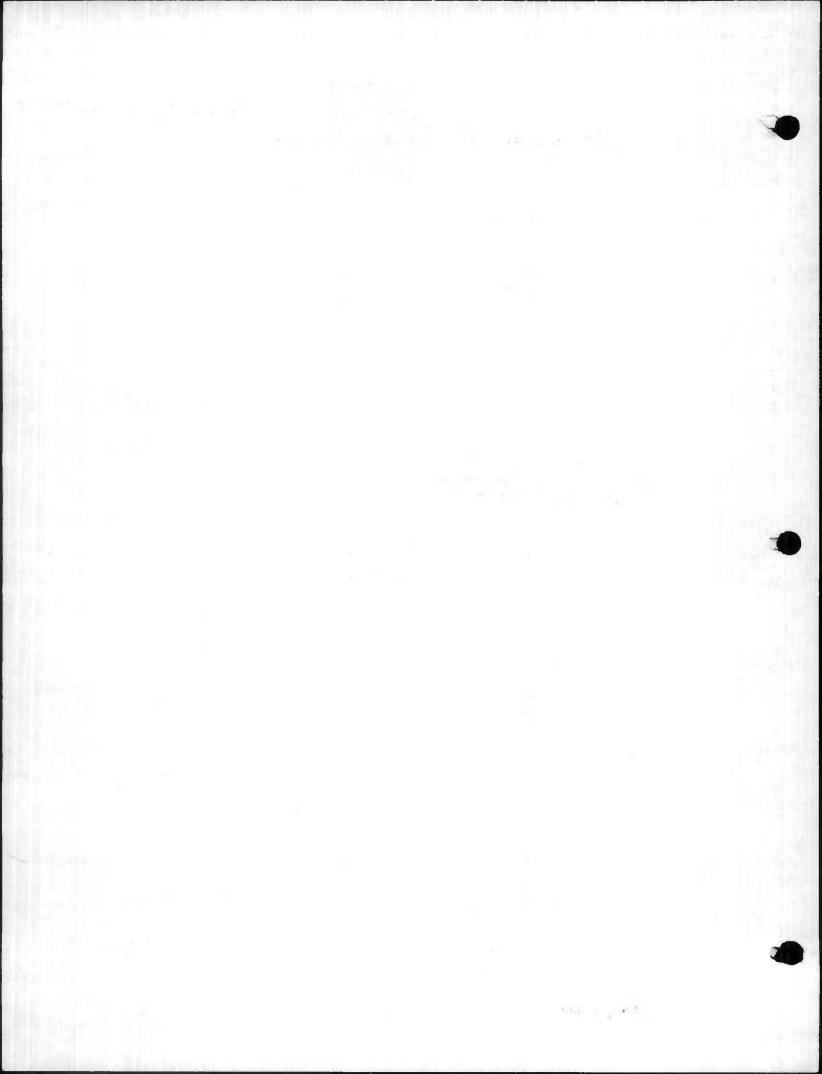
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State of Maryland / Department of Health and Mental Hygiene

					Certificate of	Death		Reg. No.		
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and		Usual Rasidence of Dacedant 10a. State 10b. County		10c. City, Tow	m or Location				100	d. Insida City Limits
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r 28e	Director	10e. Street end Number			10f. Zip Coda			10g. Citizan of V	What Country	y?
h with	O E	1031 Edmondson Av	renue		21217			United	State	S
s 1 and 2 should be filed within 72 hours aftar death with the Maryland I Health and Martel Hygiene. I Health and Martel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Eventrice man be notified at	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 Swidowed 4 Divorcad	12. Wes Dacedant E Armed Forces? 1 ☐ Yas 2 ☑ N If Yas, Giva Yaar or Dates:		13. Wes Decedant of H If Yas, specify Cub		pecify Yes or No o Rican, atc.)	Specify Bla		
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1 and 2 Health em 27 i		Mrs. Jessie Brown	1 (Cousin)		002 Presbury	y St., Ba	1			
Page nent o int: If iry or		20e. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Othar (Specify		cem ate	of Disposition (Name of try, crematory or other plant Zion Cemet	1	Jan 29 1999	20c. Location -		
permit. Departminents Imports any injt		21. Signature of Funaral Service Lican	See Man	7	22. Name end Addra Calvin L 270 Fred			l Servic		
2		23a. Pert1. Entar tha diseasa, or comp shock, or haart failura. List only	olications that caused one cause on each line	the deeth. Do	not anter the mode of dyir	ng, such es cardia	or raspiratory a	rast,	11	Approximata ntarval Betwaen Onsat and Death
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ath. rr: After	Certification:	1 Natural 5 Pending 2 Accident Invastigation 3 Suicide 6 Qould not be		28a. Data of Injury (Month, Day Year) 28b. Tima of Injury N 28c. Injury at Work? 1 □ Yas 2 □ No						
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To the Hospital or Atte within 24 hours after de To the Funeral Directo complataly filled in by the	edicai	29a. Cartifiar (Check only one) 1 CA Certifying Phy 2 Medical Example (Check only one)	ysician: To the best of liner: On the basis of a and menner stat	axamination an	a, daath occurred at tha tir d/or Invastigation, in my o	ma, data and place opinion, daath occu	, and dua to tha rred at the tima,	causa(s) and ma data and placa,	annar as stat and dua to t	ted. ha cause(s)
To th To th	W	29b. Signeture and title of certifier Colha	ya MD		29c. Licens			29d. Date signe Fan van	d (Month, De	ey, Year) , 1999
1		30. Nama and address of person who co	completed cause of de	ath (Item 23a)	(Typa, Print)	7541	Stincor	u,MD	-21	227

State Registrar

2. Registrar's Signature



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· BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

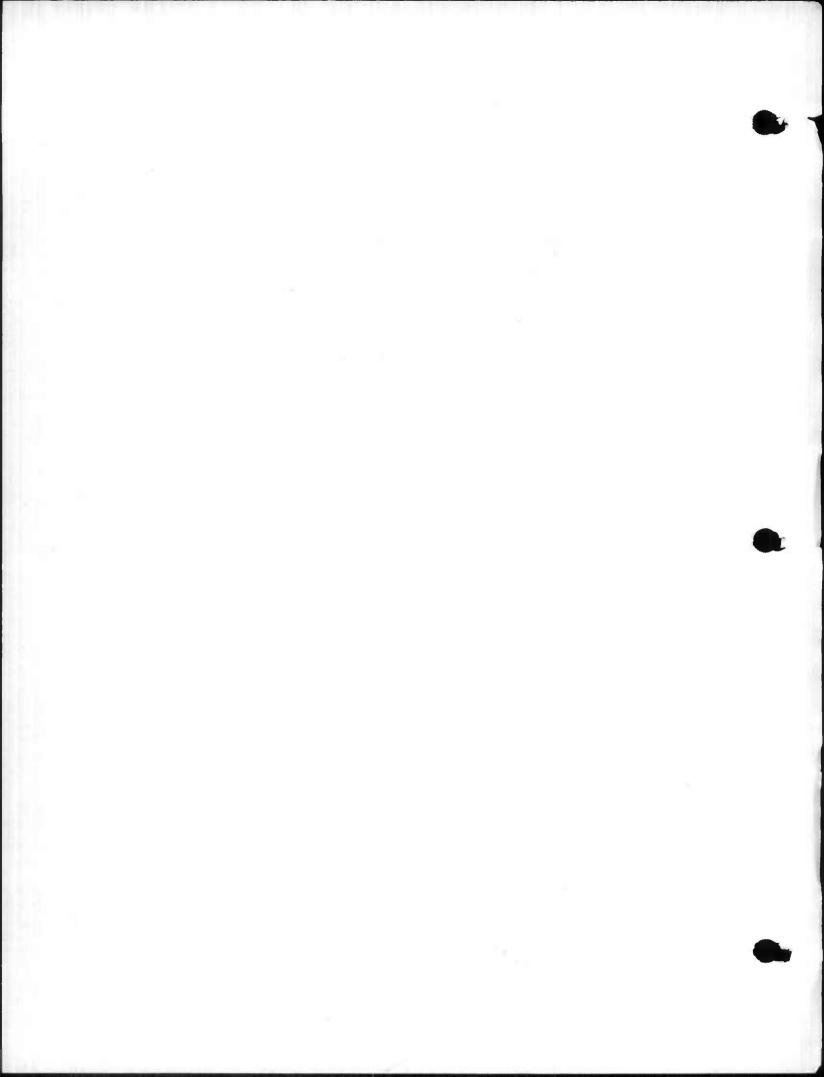
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPAR CERTIF	TMENT OF HEALTH AND ICATE OF DEATH	MENTAL HYGIENE REG. NO.	- 01003
	1. DECEDENT'S NAME (First, Middle, Last)	() 0.		2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	S. SEX 6. AGE (In viz. last hithday)		January 25	1999 7:34 PM
Į.	216-07-8602	1 🗆 M 2 💢 F 89 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH AMORTH, Pay, Year)	BIRTHPLACE (State or Foreign Country) ENGIANA
DIRECTOR	9a. FACILITY NAME (If not institution, give	18 Nulsing Ciner	96. CITY, TOWN OR LOCATION OF DI	EATH 9c. C	Baltimore
HEC	10a. STATE 10b. COUNT	Y , 10c, CIT	Y, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?
	Maryland Bay	timore Pa	RKVILE		1 TES 2 NO
FUNERAL	100. STREET AND NUMBER	le Ave	2123L	/ 10g.	CITIZEN OF WHAT COUNTRY?
FUN	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO	13. WAS DECENDENT OF HISPAI	NIC ORIGIN? (Specify Yea or No	14. RACE — American Indian, Black, White, atc.
B	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES	1 NES 2 NO Specific		Specify: White
TED	15. DECEDENT'S EDI (Specify only highest grad	e completed) (Give kind of a	USUAL OCCUPATION work done during most of working	166. KIND OF BUSINESS	1
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	topy	Proctor	+ Gamble
COM	17. FATHER'S NAME (First, Middle, Lest)	1 11 '	16. MOTHER'S NA	ME (First, Middle, Maiden Suman	10)
8	19e. INFORMANT'S NAME (Type/Print)	Whipp	ADDRESS (Street and Number or Rural	auta Me	GRATH
5	JOHN Which	7617	Daniels Ave.	Baltmore	Md 21234
e 1	20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Ren	20b. PLACE AND DATE (OF DISPOSITION (Name of	DATE 20c LOCATION	— City or Town, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	EVUID FULL	22. NAME AND ADDRESS OF FA	CILITY CALLES E	they Ma
	* KRISA	L. Wells	8800 Harto	ed Rd. Bab	timeral Chapel
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications that caused the death. Do r List only one ceuse on each line.	not enter the mode of dyling, suc	th as cerdiac or respiratory	arreat, Approximata intervai Between
	iMMEDIATE CAUSE (Final disease or condition	Congestiv	e Heart F	ail ice	Onset and Death
	resulting in death)	a. CONGESTIV	F): /	71 60 71	1
NOI	Sequentially list conditions,	b. COVON My A	rtery dise.	48 e	
CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	С			
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF	F):		
		d			
CAL	PART II. Other aignificant condition	na contributing to death but not resulting	in the underlying ceuse given in	PERFORMED?	AVAILABLE PRIOR TO
PHYSICIAN: MEDIC				1 YES 2 NO	OF DEATH?
N.					
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (Ch	neck only one)	
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outpatient 3 DOA 28a. DATE OF INJURY 28b. TIM	4 Nursing Home 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW INJURY	OCCURED
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJ	WORK7 M 1 YES 2 ND		
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, ferm, to building, etc. (Specify)	street, lactory, office	281. LOCATION (Street and Nut City or Town, State)	mber or Rural Route Number,
LET	29a. CERTIFIER 1 PICERTIEVING PHYS	SICIAN: To the best of my knowledge, desth occurr			
COMPLETED		ER: On the basic of examination and/or investigation			
BE C(296. SIGNATURE AND TITLE OF CERTIFIE		29c. LICENSE NU		DATE SIGNED (Month, Day, Year)
TO B	41- Mich	my they in	0250	705	JANUMY 25,1999
	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DEATH (ITEM 27) (Types	f. Charles St	Balto	md 2,20%
	31. DATE FILED (Month, Day, Year) JAN 2. 7 199	32. REGISTRAR'S SIGNATURE			
	JAN 2 7 199	J Deneva 19	Ana V		



DHMH-18 Rev 1/89



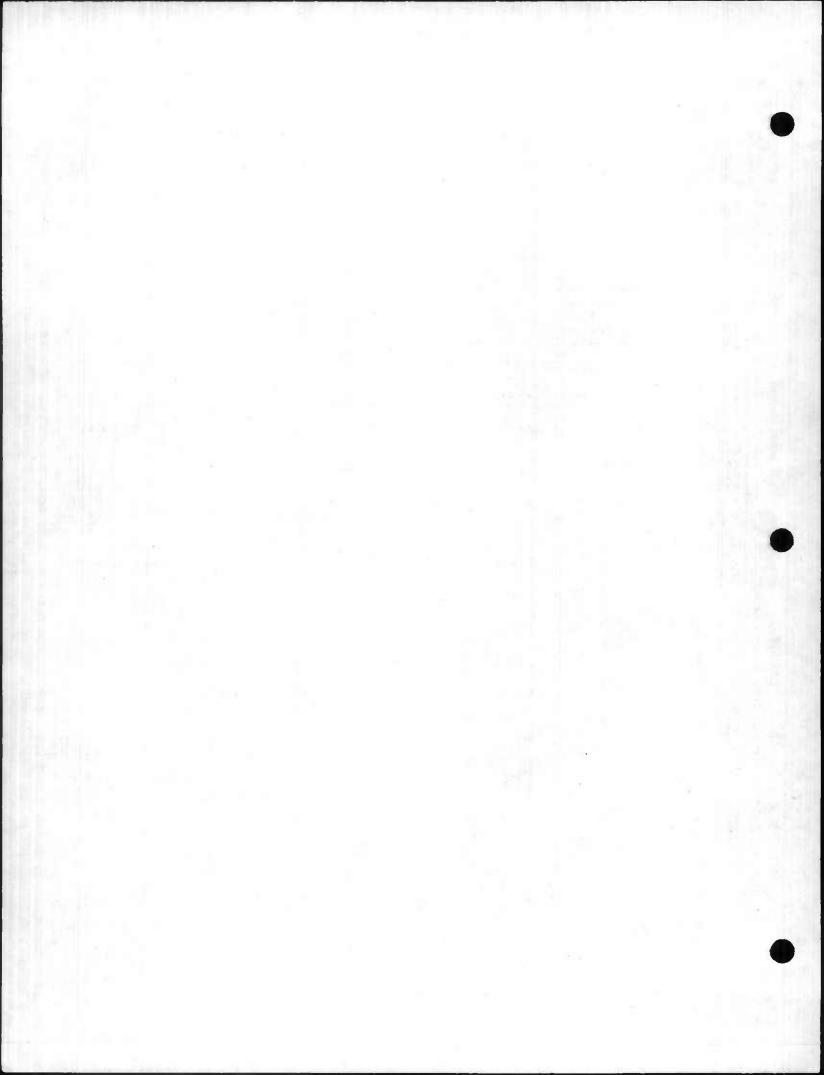
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State of Maryland / Department of Health and Mental Hygiene

01866

			Certificate o	f Death	Re	g. No.	2 0	1000
Physician	DORTC		DOYLE		2. Dete of Death Month JANUARY		Vone	3. Time of Death
/Medical Examiner	DORIS 4a Facility Name (If not institution, give		DOILE	4b. City, Town, or Lu	ocation of Death	4c. County		1747
	THE JOHNS HOPKINS 5. Social Security Number 6. Sec		st birthday) If Under 1 Ye	BALTIMORE ar If Under 24 Hrs.	8. Date of Birth		9 Rirthplac	ce (State or Fore
rector		M 200F	Yrs. Months Day		OCA. 10	1930	Mar	Yland
ner must be notified at uneral Director	Ma Balti	MORE PO	Town or Location					I Inside City Limi
Matthen ral Dir	2711 Fight	W.	101. Zip Code	11234	10	g. Citizen of W	84	
Exam	1 Nevar Married 2 Merried	12. Wes Decedent Ever in U,S Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	i. 13. Wes Decedent of If Yes, specify C	f Hispanic Origin? (Spuban, Mexican, Puerto lo <i>Specify:</i>	ecify Yes or No- Rican, etc.)	Blec	- American k, Whita, etc	ì
r, the Medical Completed	15. Decedent's Edu (Specify only highest grade		16a. Decedent's Usual Occ (Giva kind of work don life. DO NOT use ret	ne during most of work	ing	6b. Kind of Bu K. UR	siness/Indus	stry S SCho
To Be C	17. Father's Neme (First, Middle, Last)	Weinerich		Mahel	e (First, Middle, M Maril	Owe	ns	
ther traum	19e. Informent's Neme/Reletionship (Ty AARLY	ile	19b. Meiling Address (Street 2711 Fulfill) ace of Disposition (Name of	AH. BOH	more.	Md 6	11234	
ury or o	1 Burial 2 Cremetion 3 R 4 Donation 5 Other (Specify)		Metery, crematory or other p	MOTERY !	an. 29 1	ackvi	The N	lakulan
any inj once	21. Signeture of Funeral Service License	C/12/10	22. Name and Add	dress of Fecility & V	ans Fu	reeal	Chap	el
	23e. Pert1. Enter the disease, or complishock, of heert feilure. List only or	cetions that caused the death.	Do not enter the mode of o	lying, such es cardiac	or respiretory erre	HMOE st,	i in	pproximete itervel Between
ician dical	Immediate Cause (Final disease or condition	MULTIPLE ORG	AN SYSTEM FAI	LURE				Onset and Deeth
miner ច	resulting in deeth)		es e consequence of):					
s the buriet-transit	Sequentially list conditions,		CULAR ACCIDEN es a consequence of):	<u> </u>			02	2 WKS
s the burial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	SEPSIS	es a consequence of):				03	3 WKS
Z a	resulting in death) Lest	MYOCARDIAL I					02	2 WKS
Physician/	Part II. Other significant conditions con	tributing to death but not resul	ting in the underlying cause	given in Pert I.	23b. Did tol	ecco use cor	ntribute to ti	he cause of deal
be detached by Physical	HISTORY OF HEPATIC	TRANSPLANT			1 🗆 Ye	8 2□ No	3 Probei	bly X Unkno
should	IMMUNO SUPPRESSION	1	18.5		24e. Wes en perform		eveile	autopsy finding: able prior to pletion of cause ath?
ractor, page 2 Be Comp	DEEP VENOUS THROM	BOSIS			1 ☐ Ye	2 No		Yes 2□ No
Be Be	25. Was case referred to medical examiner?	ospitel: xr		Other	h (Check only one			
E G	27. Menner of Death 1 DaNeturel 5 Pending	1	28b. Time of Injury 28c. In	4 LI Nursing Pic	ome 5 Resider 28d. Describe ho		-	
by the	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Str. City or Town,		er or Rural F	Route Number,			
Funer tely fill	29e. Cartifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my know er: On the basis of examinetic end manner stated.	ledge, deeth occurred at the on end/or investigation, in m	time, date and place, y opinion, death occur	end due to the ca red at the time, da	use(s) and me te end plece, a	nner as stet	ed. ne cause(s)
To the comple	20b. Signature still life of certifier) Grant		sinse number	29	d. Date signed	(Month, De	iy, Year)
		N WOLFE ST B	ALTIMORE, MARY	YLAND 2128	7			
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrer's Signet	ire					
			A STATE	24-25				

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death SIVA(ENOBIA anuar 1999 4b. City, Town, or Location of Death 4a Fecility Neme (If not Institution, give street end number) 4c. County of Death Good Samaritan Hospital Baltimore If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Deys 10 M 20F 216-34-8894 60 Yrs. 01-14-39 NĆ Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Tyas 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 333 East 22nd. Street 21218 USA 12. Was Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, White, etc. 1 Navar Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) Elamentery/Secondery (0-12) College (1-4or 5+) 10th Grade Day Care Provider Self-employed 18. Mothar's Nama (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Williams Hardy Columbus **Emma** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Reletionship (Type, Print) 333 East 22nd. Street Baltimore, Maryland Phillip Davis 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete Woodlawn Cemetery 01-29-99 Woodlawn, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerel Sarvice Licenson 22. Name end Address of Fecility Baltimore, Maryland @1202 email D mour WM.C.March FH 1101 E. North Avenue Approximate Intervel Between Onset and Daath 23a. Part1. Enter the disease, or con plications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Finel disaesa or condition resulting in death) Due to (or es e consequende ot): encepho lopathe 12 0x fruic Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of/ Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Ufiknown 24b. Ware eutopsy tindings aveilable prior to completion of cause of death? 24e. Was en autopsy useon 1 Yes 2 NO 1 Yas 20-No 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 /mpatient 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending

and -transit The law gequires that the death certificate be executed physician an s the burial-tr P.O. Box 68760 88 for use as ed by the a signed by t Records, been si i certificata hes l Division of Vital or Attending Physicien: director, this funeral death. Director: A after within 24 hours after To the Funeral Direc completely filled in b Hospital ş

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 end 2 should be filed within 72 hours after death with the Marylen neat of health and Mentel Hygiene. Intit if them 23a or 28a-f shown int: if them 27 is marked other than "natural", or items 23a or 28a-f shown ny or other traumatic event, the Magass Example in the 10-filed st

permit. Pages Department of Important: If it eny injury or o

Physician /Medical

Examiner

Physician/Medicai Examiner

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Certification:

Medical

Baltimore, Maryland 21215-0020

25. Wes case referred to medical examiner? 1 Yes 27 No 27. Menner of Deeth 1 DMaturel 1 Yes 2 No investigation 2 Accident 6 Could not ba 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

0

1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at tha tima, data end placa, and due to the ceuse(s) and menner steted. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

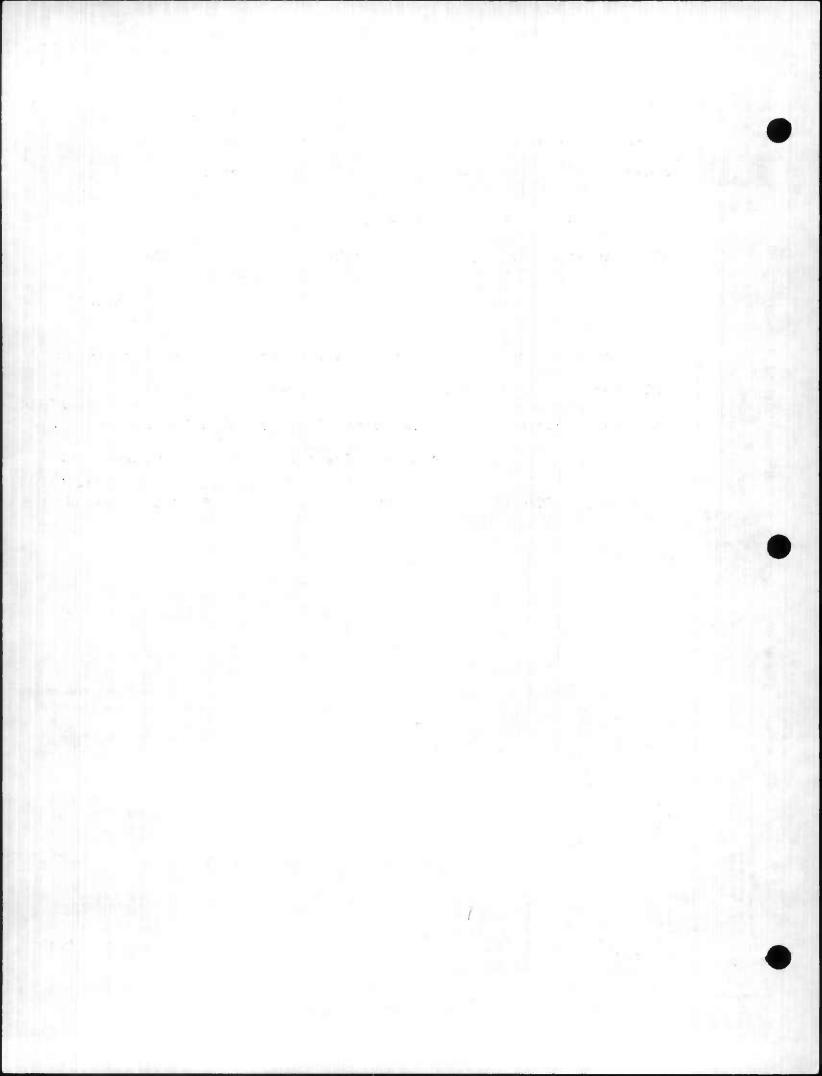
completed cause of deeth (Item 23e) (Type, Print)

Zoch 32. Registrer's Signeture 31. Data tiled (Month, Day, Year)

State Registrar

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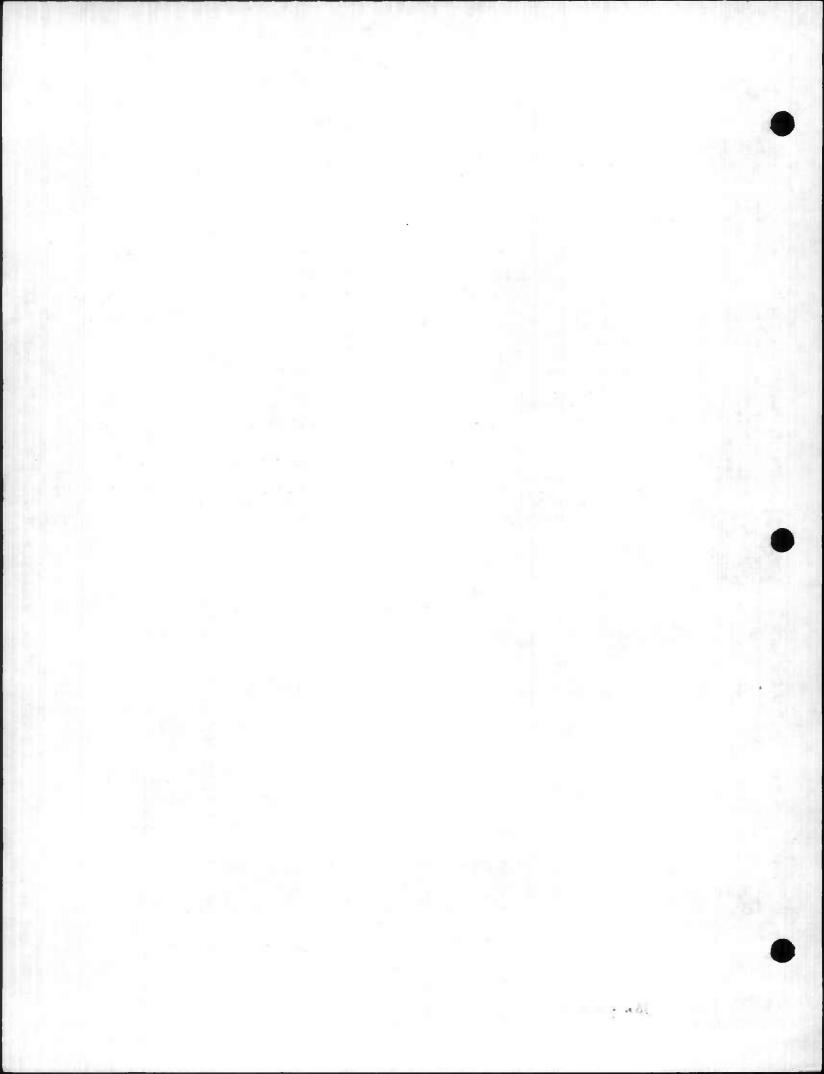
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State of Maryland / Department of Health and Mental Hygiene 99 0 | 868

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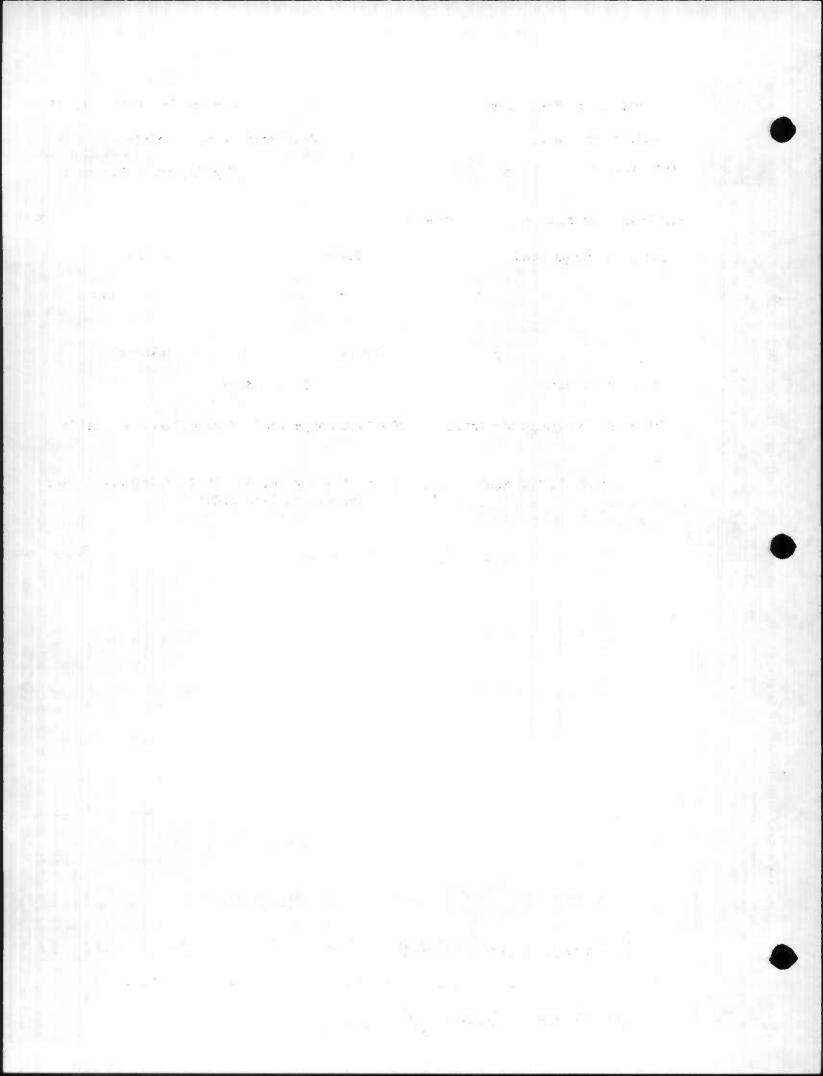
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Registrar



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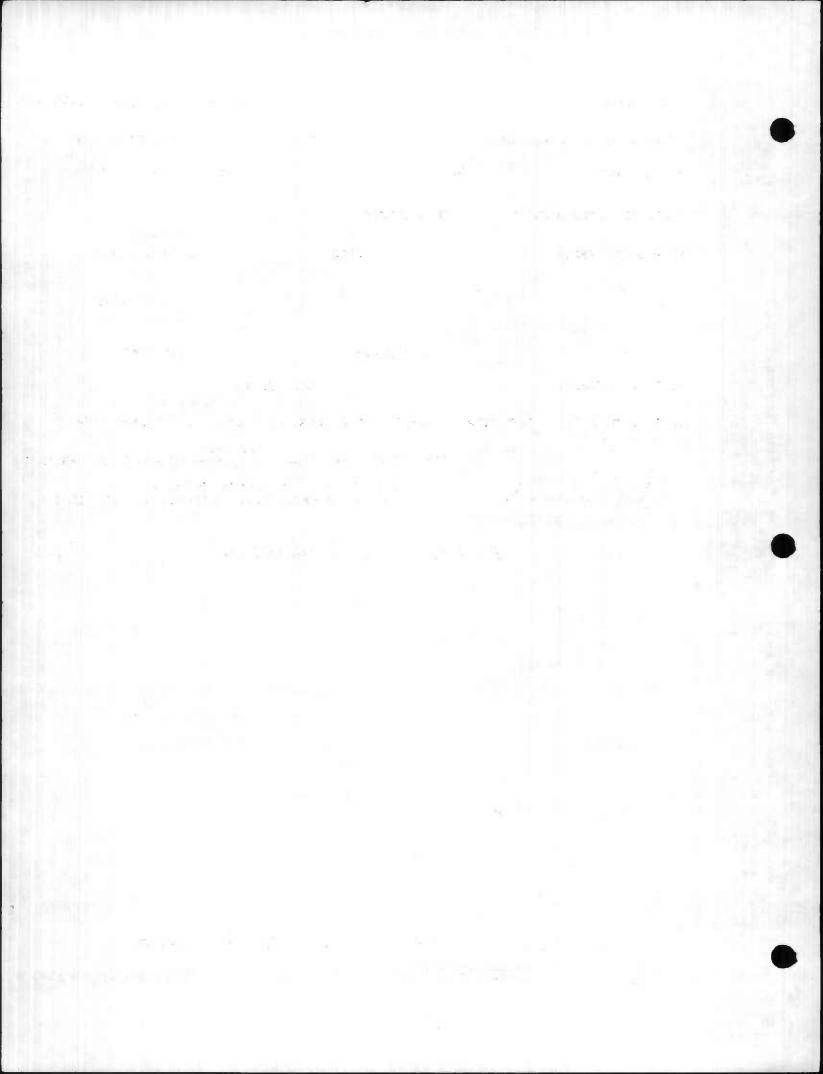


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** JANUARY 23, 1999 9:10 P.M. RUBY ESPY /Medical 4b. City, Town, or Location of Deeth 4e Facility Nama (If not institution, giva street and number) 4c. County of Deeth Examiner HARBOR HOSPITAL CENTER BALTIMORE BALTIMORE CITY If Under 1 Yaer | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplaca (Stete or Foreign Country) Funeral Months 1□ M 2♥ F Deys Hours Min. 93 Yrs 340-38-2032 1905 ALABAMA Director APR. 13, Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumatic avant, the Modical Examine, must be notified at MARYLAND ANNE ARUNDEL GLEN BURNIE 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6436 POLK CIRCLE 21061 UNITED STATES Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yas, Give Yeer or Detes: 11 Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - Amarican indian. Bleck, White, etc. e filed within 72 hours efter all Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Maryland 21215-0020 Specify: WHITE PV 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fethar's Nema (First, Middle, Last) 12 should be fill h end Mental H Is marked oth WILLIAM RUTLEAGE LERA BRYAN 19e. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurei Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2 sh Department of Heelth end Important: If Item 27 Is m any Injury or other traum once. JANELLE M. ADAMS / DAUGHTER 6436 POLK CIRCLE, GLEN BURNIE, MARYLAND 21061 Baltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition JANUARY 1 □ Buriai 2 ☑ Cremetion 3 □ Removel from State METRO CREMATORY, INC. 4 ☐ Donetion 5 ☐ Other (Specify) 25,1999 CATONSVILLE, MARYLAND 22. Name end Address of Fecility 21. Signature of Fugeral Service Licensee KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, 21061 MD Approximate intervel Between Onset and Deeth 23a. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. **Physician** Immediate Ceuse (Finel disaase or condition resulting in death) RS /Medical DEMBNI/A A LZHEIMERS **Examiner** Examiner physician end s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disaese or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): certificate be exec Box 68760, Physician/Medical Due to (or as e consequence of): SE 950 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 3 Probably 4 Unknown 1 Tyes 2 No þ 24b. Were eutopsy findings available prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy peed page 2 1 ☐ Yes 2 No 1 TYPE 2 No certificate Division of Vital or Attending Physician: director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Hospitel: 1 ₺ inpatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☒ No this funeral 27. Manner of Deeth Dete of injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 1 Neturet 5 Pending Investigation 1 ☐ Yes 2 No 2 Accident ofter deet Diractor: 6 Could not be determined 3 ☐ Suicida 28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide A Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and plece, end due to the cause(s) and mannar stated. 29e. Certifier Medical (Check only one) within 2 To the 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 17753 - am 1 ham JANUARY 25, 1999 30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) 710 CHERCH ST. BALTIMORE, MD21225 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State JAN 27 1999 Registrar Sparka



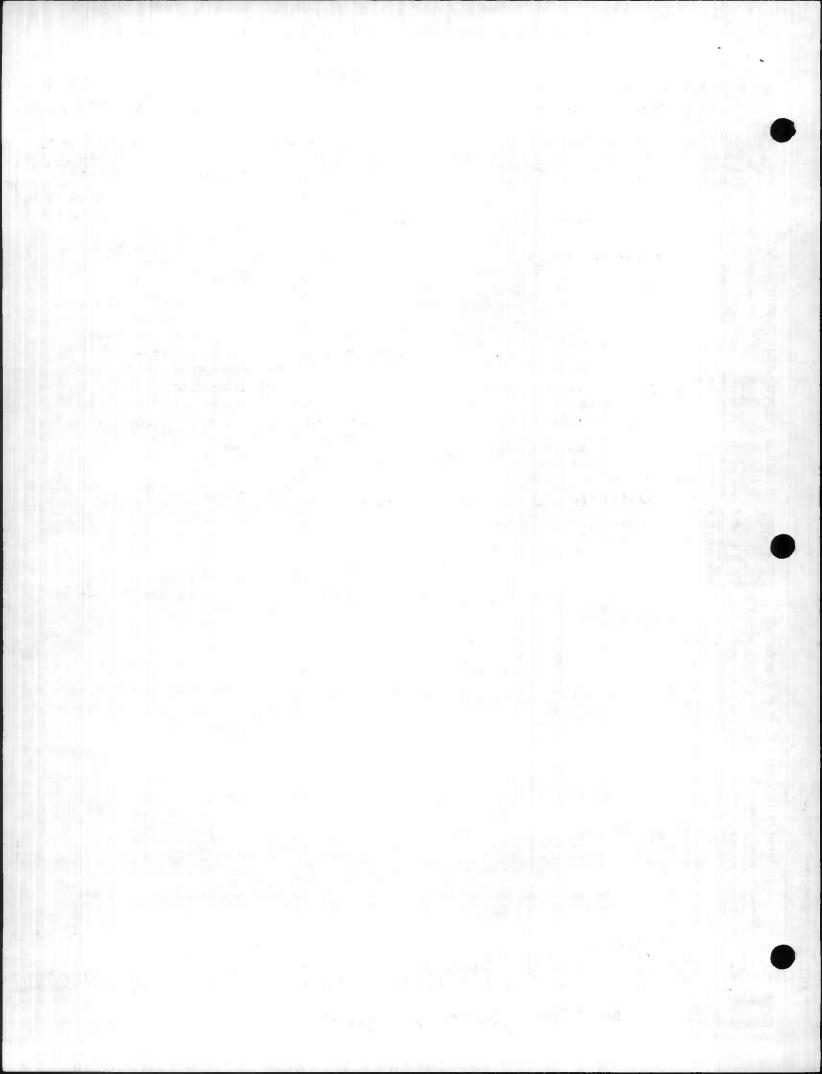
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death **Physician** Herbert Gottlieb January 14, 1999 6:00 P.M. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery County If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) BTOOKLYN, 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** 1 M 2 □ F Months Deys Hours Min. Yrs. 065-18-8732 74 New York May 23, 1924 **Director** Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No New York Kings Brooklyn Directo 10g. Citizen of What Country? United States 10e. Street end Number 10f. Zip Code than "natural", or items 23a or the Med cel Examiner must be 495 East 7th Street 11218 of America Funeral illed within 72 hours after death 12. Was Decedent Ever In U.S. Armed Forces? 1 M Yes 2 □ No 1943 If Yes, Give Year or Detes: 1945 Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) New York City Elemantary/Secondary (0-12) College (1-4or 5+) (Justice) Court Officer d other 18 Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) 1 and 2 should be Haalth and Mantal 7 is marked traumatic ev Benjamin Gottlieb Lillie Schechter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) nt of Health at: If Itam 27 Is Melvin Gottlieb/ Brother 913 Annmore Drive, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete Buriel 2 Cremetion 3 Removel from State January Department of Important: If any Injury or 17, 1999 Cedar Park Cemetery Paramus, New Jersey 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility 21. Signature of Funeral Service Licensee 11374 Parkside Memorial Chapel lasson 98-60 Queens Boulevard, Forest Hills, New York 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Finet diseasa or condition rasulting in daath) /Medical 9 Examiner Dua to (or es e consequance of): Examiner umoni 0 physician and tha bunal-transit requires that the death certificate be axecuted Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated avants rasulting in daeth) Lest Due to (or es e consequança of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): for usa as signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by Com 24b. Were eutopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of daeth? nis cartificata has b 2 No 25. Was casa rafarred to medical exeminer? Be 26. Place of Deeth (Check only ona) 1 Yes 2 No Hospitel: tnpatiant 2 ER/Outpatiant 3 DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify) OL this funaral 28d. Dascribe how injury occurred 27. Magnar of Death 28b. Time of 28c. fnjury et Work? Certification: Attending Neturel 5 Pending 1 Tyes 2 □ No death. 2☐ Accident investigation by tha 6 Could not be determined 3 Sulcide 28e. Pteca of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 4 - Homicide 6 古 the Funeral Di 1X Certifying Physician: To the bast of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated.

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304 leby Herbert



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month Yaar 6:00 PM 23, Regina G. Gil1 1999 Jan. 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Manor Care Towson Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | Nov. 4, 1908 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign 1 M 2 M F 90 Yrs. Maryland 214-20-8953 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 PNo Md. Baltimore Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 2312 Harford Hills Rd. 21234 U.S.A. 12. Was Dacedant Evar In U,S. Armed Forces? 1 ☐ Yes 2 ᠫ No It Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 □ Naver Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Surname) Gertrude V. Louis Yuhn Lafferty 19a. Intormant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary R. Howard/Daughter 2312 Harford Hills Road Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 1/25/99 New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Rd. 23a. Part1. Entar tha disease, or complications that ceuse shock, or heart failure. List only one cause on each the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yes 2 No 1 Yes 2 No 26. Placa of Death (Check only one)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

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permit. Pages 1 and 2 should be file.
Department of Health and Mantel Hy
Important: If Item 27 is marked other
any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

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Box 68760. P.O. Division of Vital Records, certificete Physician: director, After this uneral or Attending deeth. efter deeth Director: 3 Hospital 24 hours within 2 To the I 94

Part It. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 25. Was casa referred to medicel Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner ot Death 28c. Injury at Work? 28d. Describe how injury occurred 1- Neturet 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homtcide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one)

30. Name and address of percompleted cause of

29b. Signature and title of cq

Type, Print)

29d. Date signed (Month, Day, Year)

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29c. License number

21284

State Registrar

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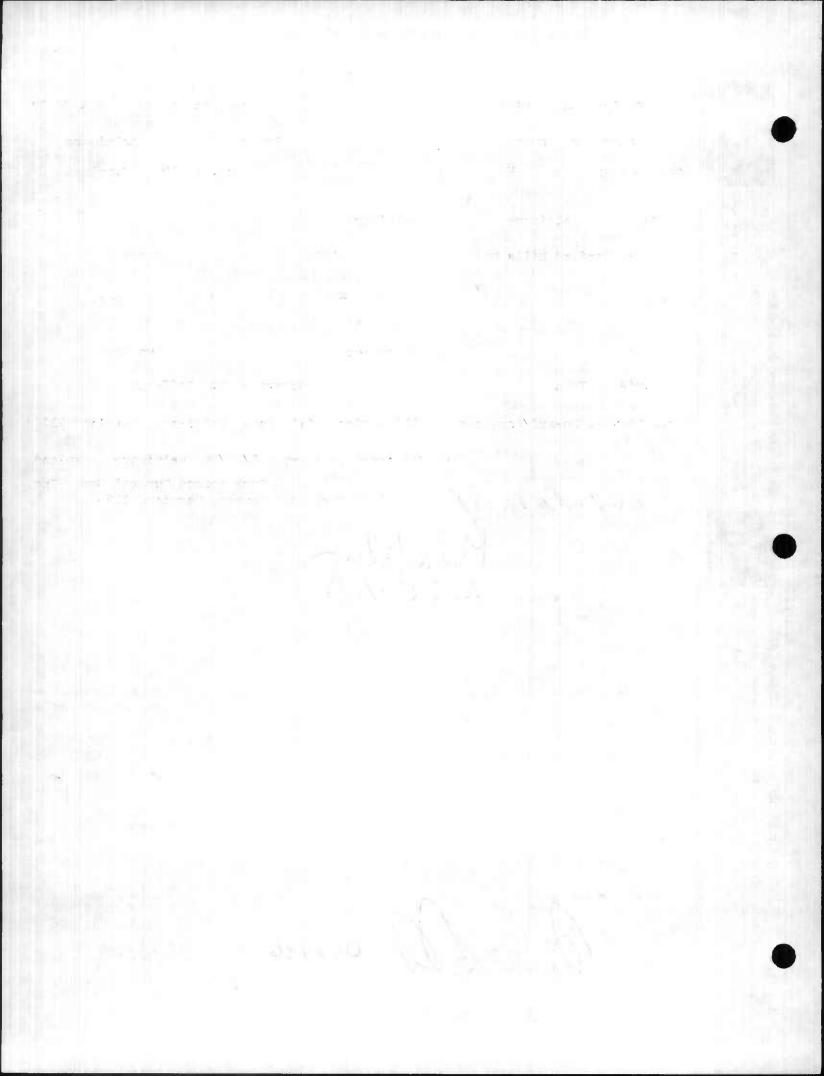
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32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 99 01873

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month
January 26

Peath Jc. County of Death **Physician** FRANCES 0730 AM GARBER 26 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner Baltimore City BALTIMORE HARBOR HOSPITAL CENTER If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan. 22, 1926 Mary Land If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2Å F Deys 73 Yes 219-18-5002 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Severna Park 1 ☐ Yes 2 ☒ No 288-1 Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23e or United States 21146 52 Holly Rd. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Narried altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Artist 10 permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 89 Rose Guariglia Lawrence S. LaMonaco 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52 Holly Rd., Severna Park, Maryland 21146 Joel Garber, Sr. / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cematery, cremetory or other piece) 27 Jan. 1999 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State Catonsville, Maryland 4 ☐ Depation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Gicenses 22. Name end Address of Fecility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final mythe METASTATIC GASTRIC CANCER disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es a consequença of) 080 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed certificate has 2 XNO 1 ☐ Yes 2 ☐ No 1 Yes of Vital 25. Was case referred to medical 80 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2N No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred edical Certification: a for Attanding P after death.

I Director: After to in by the funers Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 T Homicide To the Hospital o within 24 hours aff To the Funerel Di completaly filled in 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 26 an aut y 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR GAYATR) NIM MAG ter 5. Harbor t 205 Cen 3001

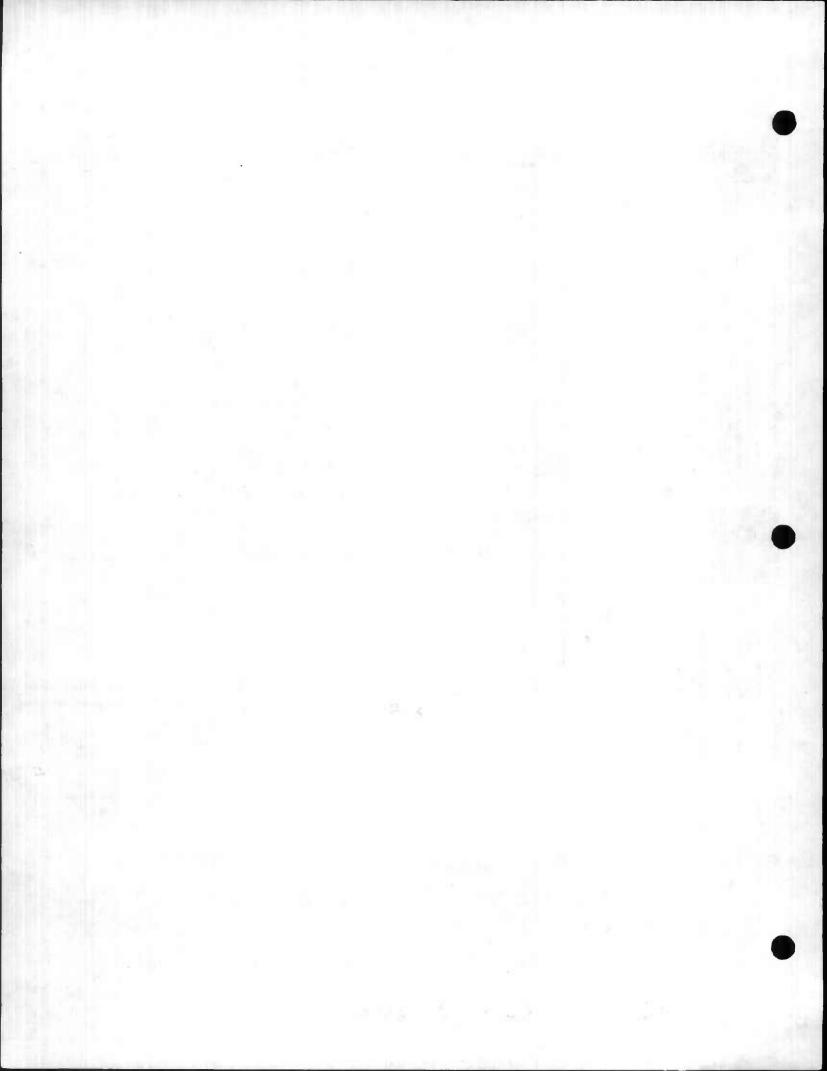
DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

1999

32. Registrar's Signature

UD 21225



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Guckert 01 20 - 992:30 P.M. Douglas Μ. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4239 Necker Avenue Baltimore Baltimore If Under 1 Yeer If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9/11/1962 **Funeral** 1☐M 2□F Months 212-92-0673 Director Maryland Usual Residence of Decedent 10a Stete 10b. Counts 10c City Town or Location 10d. Inside City Limits 28a-f show MD Baltimore Baltimore 1 Tyas 2000 Directo 10f. Zip Code 21236 10e. Street and Number 4239 Necker Avenue 10g. Citizen of What Country? 8 U.S.A. "natural", or Items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 11. Marital Status 1 Lyes 2 □ No If Wes, Giva Year or Dates: 1 CNever Married 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: P 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Cleaning Maintanence pemit. Pages 1 and 2 should be tile.
Department of Heath and Mental Hy,
Important: If Nem 27 is marked other any Injury or other 1-18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Carolyn Thorton George Guckert Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) George Guckert Sr. 4239 Necker Avenue Baltimore, Maryland 21236 20b. Plece of Disposition (Name of 20c. Location - City or Town, Steta 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Parkwood Cemetery 1/23/99 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility John C. Miller Inc. 21. Signeture of Formal Service Licen 6415 Belair Road Baltimore, Maryland 21206 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one pause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) 3 weeks Hepatic encephalopathy Examiner Examiner circhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events Due to (or as a consequence of) the burial-tran attending physician +epotitis Box 68760 Physician/Medical that initieted events rasulting in death) Last Dua to (or as a consequence of): 98 patitis Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown malnutrition 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2MNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Neturel
2 Accident or Attending 5 Pending investigation To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Af 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide McCertifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner as steted.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. edical 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie D00528

DHMH 16 Rev 6/95

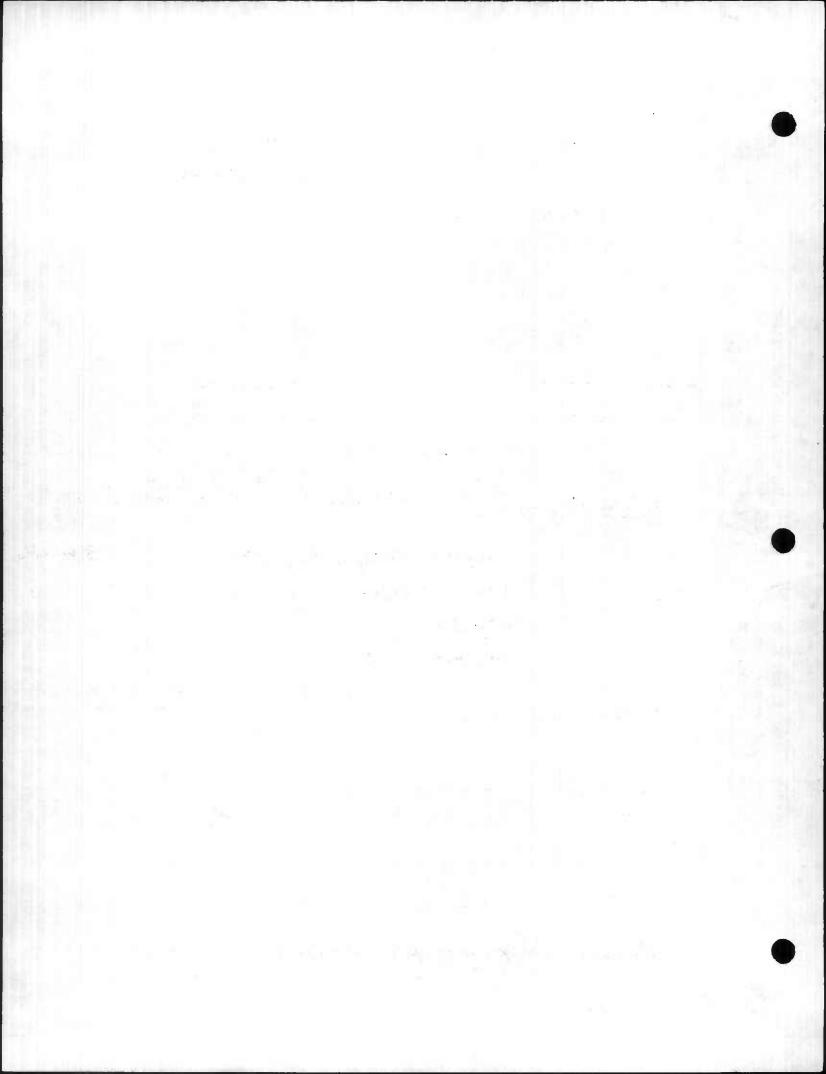
State Registrar

31. Dete filed (Month, Day, Year)

ALEXANDER PNIEL 32. Registratr's Signeture JAN 27 1999

30. Name end address of person who completed cause of death (ftem 23a) (Type, Print)

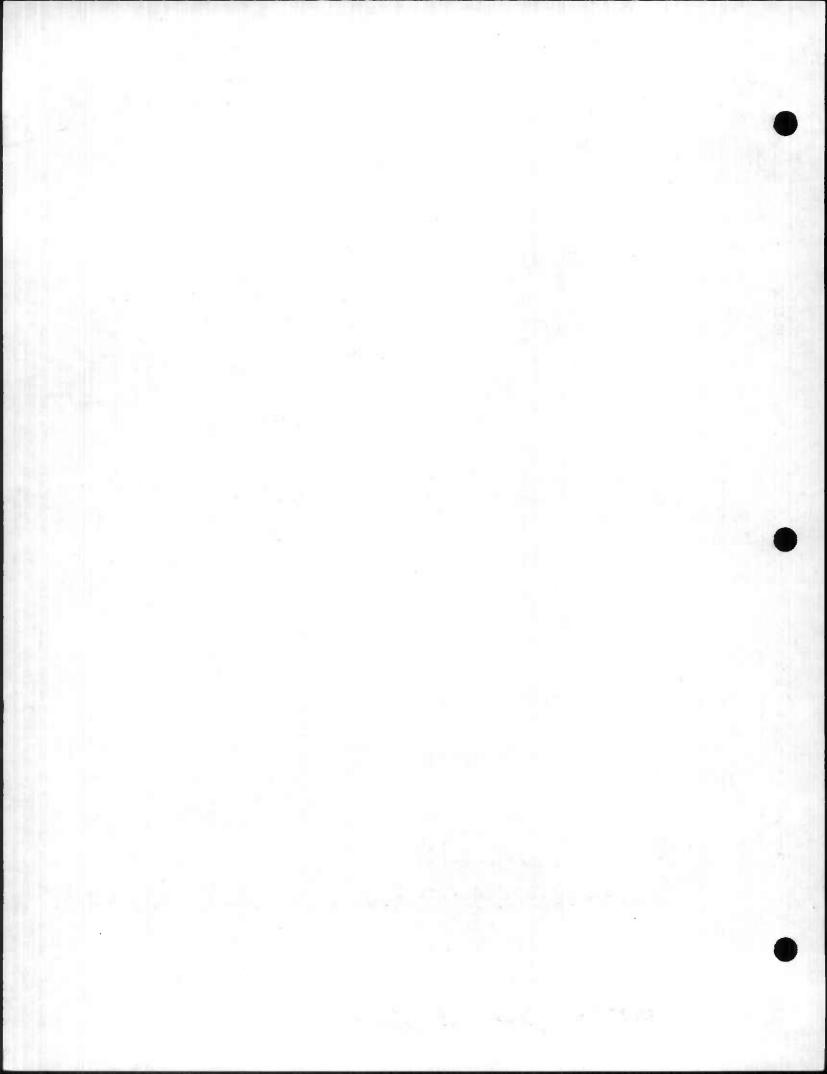
GOLD FRANKLIN SURRE DR. BAKTO. Md 2023



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Certifica	te of	Death		Re	g. No.			
	1. Decedent's Name (First, Middle, Las	0					2	2. Date of Death	1		3. Time of Death	
Physician /Medical	Ruth E. Hanna						Month January			4:00 AM		
Examiner	4a Facility Name (ff not institution, give	street and number)				4b. City, Tow		ation of Death	4c. County			
	Presbyterian 1	Home of Ma	rylan	d		Towso	n		Balti	imore		
Funeral Director	5. Social Security Number 6. Se		yrs. last bin		Days	If Under 2 Hours	4 Hrs. 8 Min.	3. Dete of Birth (Month, Day, Oct. 20			lece (State or Foreitry)	ign
	Usual Residence of Decedent							UCL. ZI	7, 1710	um	known	
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of first death with the Ma r thems 23s or 28s-1s for must be norther Funeral Director	10e. Street and Number 400 Georgia Aven	110			ip Code	,			g. Citizen of W	/hat Coun	lry?	
the safe	11. Marital Status	12. Wes Decedent Ever i	n U.S.	-			in? (Speci		J.S.A.	- Amaric	an Indian.	
020 uns by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		100000	Wes Decedent of Hispanic Origin? (Specify Yas or N II Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 No Specify:					k, While, a		
S-0	15. Decedent's Edu	ucation	16a.	Decedent's Us	ual Occup	pation	of working	. 1	6b. Kind of Bu	siness/inc	lustry	
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Pording People					<u> </u>			24a. Was ar perform		COL	ere autopsy lindings eilable prior to mpletion of cause death?	S
The law page 2 Compl								1 ☐ Ye	s 2MNo	1	Yes 20 No	
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ithin 2 of the complex Mec	29b. Signeture end title of certifier	and manner steted.		2	C. Licens	se number		29	d. Date signed	(Month	Dey, Year)	
F ¥ F 8	→ 7C	Attending	m	0	03	170/1			Janks	5 2	1, 1999	
	30. Name and address of person who or Kenneth in Green	ompleted cause of death (Item 23a) (Type, Print) (Leves	st,	Sc.ta	4	105	Saltino,	~,~	0 2120	04
State Registrar	31. Date filed (Month, Day, Year) JAN 2 7 1999	32. Registrar's Si		Som y	,							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1999 JANUARY 26 01:50 AM 4a Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country) Deys 10 M 200 F Months Hours Min -28-290 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2/2 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Mentel Stetus Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ublic Health Elementary/Secondary (0-12) College (1-4or 5+) Le RVICES 8. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First Middle Last) 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan. 29 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Fuheral Service License 22 Name and Address of Fecility Chapel vans 23a. Part1. Enfer the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final

Physician /Medical Examiner

The law requires that the deeth certificate be executed

Attending Physician:

deeth. 6

within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fi

To the Within 2

Division of Vital Records. P.O. Box 68760.

Physician

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permit. Peges 1 and 2 should be flied within 72 hours after. Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or her eny injury or other traumatic event.

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disease or condition resulting in deeth) Examiner physician and s the bunal-trans

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. by

23b. Did tobacco use contribute to the cause of death?

29d. Date signed (Month, Day, Year)

3 Probably 4 Unknown

1 □ Yes 3 No

		24a. Was an autopsy performed? 24b. Wera autopsy findings evailable prior to completion of cause of death?				
		1 Yes 2 No 1 Yes 2 No				
25. Was case referred to medical examiner?	26. Plece of Deeth	(Check only one)				
1 ☐ Yes 20 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Other (Specify)				
27. Menner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Dey Year) Injury Work?	28d. Describe how Injury occurred				
3 Suicide 6 Could not be determined		28f. Location (Street and Number or Rurel Route Number, City or Town, State)				
	nysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examinetion and/or investigation, in my opinion, death occurre and manner stated.					

State Registrar

31. Date filed (Month, Day, Year) 1999

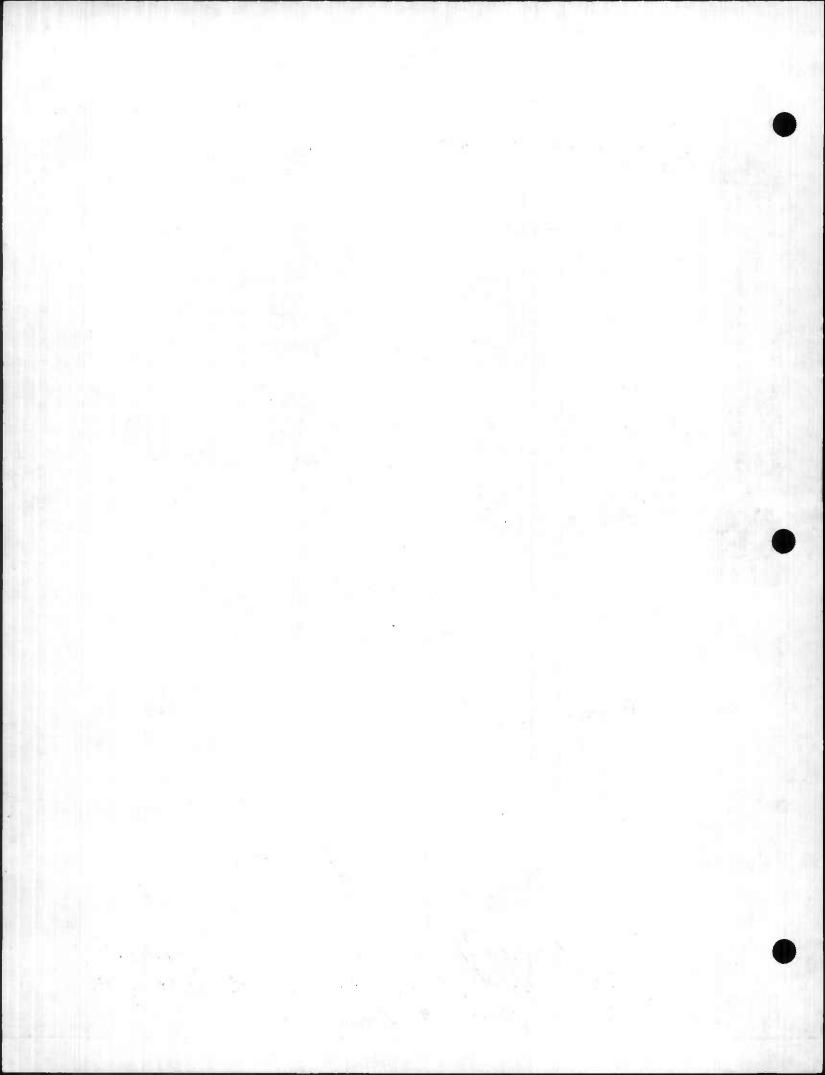
29b. Signature and title of certifie

30. Name and

32. Registra

eath (Item 23a) (Type, Print)

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Harris Raymond JAMUARY 22 1999 7:48 PM 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deatts' 4c. County of Deeth Rosedale Square 0 6. Sex TRANKLIN HOSPILAL Cenler BAITIMORE If Under 24 Hrs. B. Dete of Birth (Month, Day, Year) May 30, 1911 5. Social Security Number If Under 1 Yee 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months Deys 1 M 2 F 427 18 8505 87 Tennessee Usuel Residence of Decedent t0b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Essex 10e. Street and Number 10f. Zlo Code 10g. Citizen of Whet Country? 303 Liberty Road 21221 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Yeer or Detes: WW 2 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status t4. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Electronics Technician Aero-Space 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Elizabeth R. Ryles William W. Harris 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 303 Liberty Road Essex, Maryland 21221 Vernon Crouse 3rd (grandson) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) 1/26/1999 Baltimore Maryland Oak Lawn Cemetery 21. Signeture of Funerel Service License 22. Name and Address of Eacility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 DURKOUSKO Approximete 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear tailure. List only one cause on each line. Onset and Death ulmonary Immediete Cause (Finel diseese or condition resulting in deeth) em Chrom bos vein Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot) Due to (or es e consequence ot): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Morred 24b. Were eutopsy findings evailable prior to completion of cause ot death? 24e. Wes an eutopsy performed? moteur Honorom 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medicel exeminer? 1 Yes 2 No 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 DER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Injury 27. Menner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dev Year) 28c. Injury et Work? 1 DNatural 5 Pending 1 Yes 2 No 900 AM Fell OUT OF The Chair 281. Location (Street and Number or Rural Route Number, City or Town, State) January 19,1999 2 Accident 6 Could not be determined S Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

Examiner Examiner icien and burial-transit The lew requires that the death certificate be executed physicien the burial Box 68760 US8 P.0. Records, Division of Vital this Attending deeth 24 hours after deeth e Funeral Director: / bletely filled in by the ò Hospital

Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

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If Item 27 is marked other than "natural", or

Department of Important: If Its any Injury or o

Physician

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Maryland

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Completed

To the Hosp within 24 hos To the Fune completely fi

DHMH 16 Rev 6/95

State Registrar

edical

29e. Certifier

(Check only onel 29b. Signeture

DR. GUNTA

31. Date filed (Month, Day, Year)

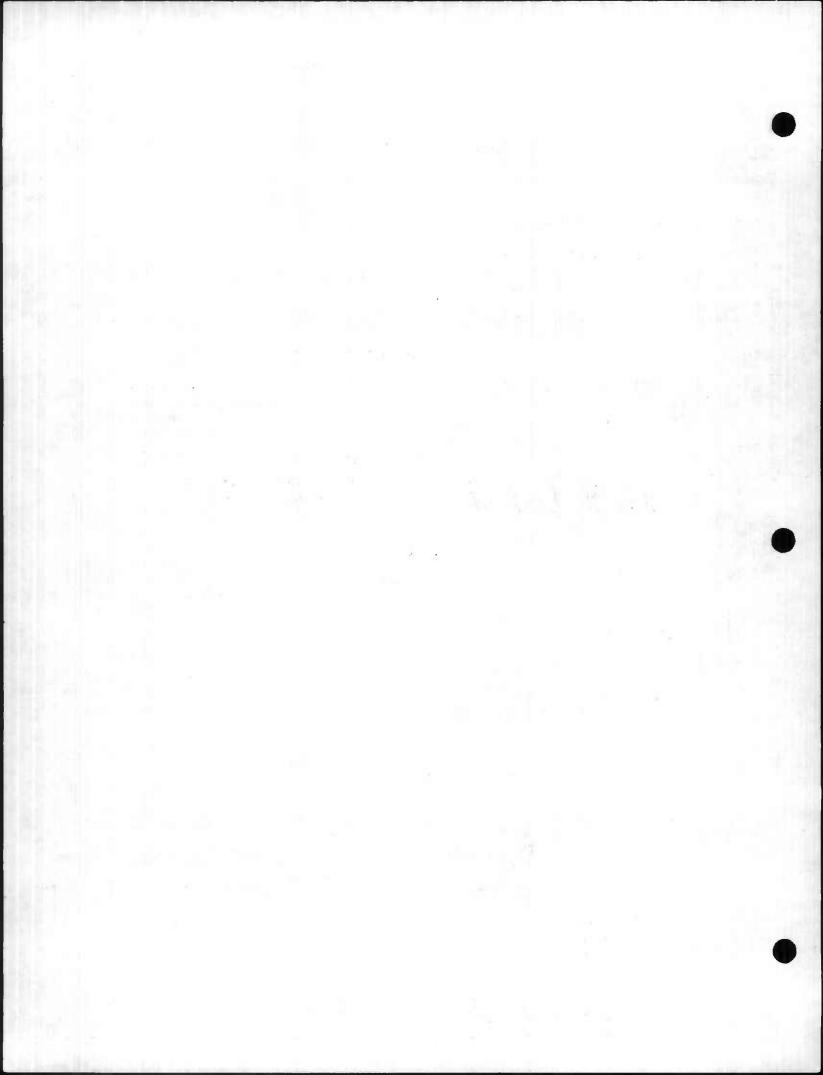
32. Registrar's Signeture JAN 27 1999

9000 FRANKlin

person who completed ceuse of death (Item 23a) (Type, Print)

BAITIMORE, MARYLAND 21237 QUARE DR.

Wheeler



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 19b Per FH Film G767 1-28-99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month harles Howell 12:40 pm 23 99 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number,

If Under 1 Year

10f. Zip Code

16a. Decedent's Usual Occupation

8034

Schemic

Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as e consequence of):

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

bronary

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Jarrison Forest Vet

Name and Address of Facility

arch F.H. Wes

Justo dian

Days

21202

1 ☐ Yes 2 ☐ No Specify:

(Give kind of work done during most of working life. DO NOT use retired)

Months

Street

10c. City, Town or Location

7. Age (In yrs. last birthday)

69

Street

12. Was Decedent Ever in U,S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Yeer or Detes:

College (1-4or 5+)

NA

100 M 2□ F

Baltimore II Under 24 Hrs. 8. Da

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.)

Hnnie

Neighbors

heart disease

artery disease

Min.

18 Mother's Name /First, Middle, Malden Sumeme

Date

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Boddie

1-28-99 Owing

24e. Wes en eutopsy

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Death (Check-only one)

1 ☐ Yes/ 2 No

28d. Describe how injury occurred

9. Birthplace (State or Foreign Country)

10g. Citizen of What Country?

U.S.

16b. Kind of Business/Industry

Avenue Baltimore, MD. 21237

20c. Location - City or Town, State

14. Raca - American Indien, Bleck, White, etc.

Specity: Black

ity Schools

Ma 10d. Inside City Limits

1 Nes 2 No

Approximate Interval Between Onset and Death

2 years

24b. Were autopsy findings eveileble prior to

completion of cause of death?

1 Yes 2 No

mnediate

Physician /Medical Examiner **Funeral** Director r 28a-f show Director 6 Funerai P

> 2 permit. Pege Department Important: if any Injury o **Physician** /Medicai **Examiner** Examiner physician end the buriel-trensit certificate be executed Physician/Medical ed by the Division of Vital Records, P.O. signed by t P Completed Be 2 this Certification: After Attending death. Director: ò Hospital 24 hours e Medical completely To the Within 2

tisquith 6. Sex 7.1 5. Sociel Security Number 219-22-8618 Usual Residence of Decedent 10b. County 10a. State 10e. Street and Number nit. Peges 1 and 2 should be filed within 72 hours after death with strings of Health and Mentlel Hygiene.
ortant: If item 27 is marked other than "natural; or items 23a or injury or other traumatic event, The Modes Examinat ment to a linkury or other traumatic event, The Modes I. 633 N. Aisquith 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 18th grade 17. Fether's Name (First, Middle, Last) Be Wallis Howel 19a. Informant's Name/Reletionship (Type, Print) Leel-Nephew Warrace 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. Diabetes Mellitus Hypertension

25. Was case referred to medical exeminer? 27. Manner of Death 29a. Certifier (Check only one)

1 Yes 2 No

1 Netural

2 Accident

3 Suicide

4 | Homicide

28a. Dete of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of certifier MO

Peripheral vascular athersclerotiz

29c. License number D35363 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

23b. Did tobacco use contribute to the cause of death?

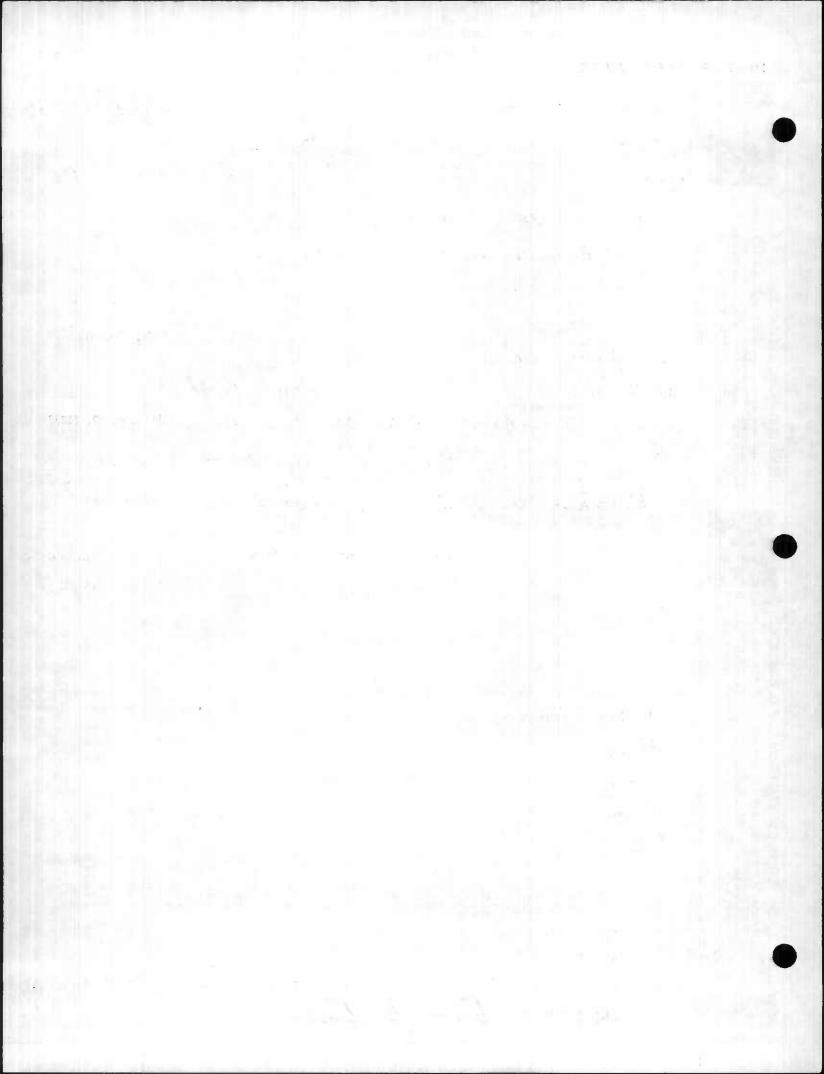
1 ≥ Yee 2 No 3 Probably 4 Unknown

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Baltimore VA Medical Center 10 N. Greene St. Baltimore MD Sandra Marshall 31. Date filed (Month, Day, Year) 21201 JAN 2 7

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Registrar



1. Decedent's Name (First, Middle, Last) **Physician** Mary /Medical 4a Facility Name (If not institution, give street and number)

10a State

Margarette

Heaster

2. Date of Deeth January 25, 1999 3. Tima of Deeth 7:15pm

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

Examiner

Perring Parkway Nursing Home

4b. City, Town, or Location of Death Parkville

4c. County of Death Baltimore

Funeral Director

the Meryland

Baltimore, Maryland 21215-0020

Physician /Medical

Examiner

ettending physician end for use as the burial-transit the death certificate be executed

ed by the e

signed by t

hes

certificate Physician:

this

After or Attending

the Funeral Director: After and filled in by the fu

To the within 2

Records, P.O. Box 68760,

The lew requires

Examiner

Physician/Medicai

þ

Completed

Be

P

Certification:

r 28a-f show Directo 1 and 2 should be filed within 72 hours efter death with Health end Mental Hyglene.

em 27 is marked other then "natural", or items 23e or ither treumstic event, the Medical Expressions. Funeral þ Completed permit. Peges 1 and 2 should be filed w. Department of Health and Mental Hyglen Important: if Item 27 is marked other the any Injury or other traumatic event, II and ence.

7. Age (In yrs. last birthday) 1□ M 2₩ F 77 213 40 0551 Usuat Residence of Decedent

Yrs.

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | West Virginia

10c. City. Town or Location

Middle River 10f. Zip Code

10g. Citizen of What Country? USA

10e. Street and Number 207 "3c" Middleway Road

Maryland Baltimore

10b. County

12. Was Decedent Ever in U,S. Armed Forces?

Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

21220

14. Race - American Indian, Black, White, etc. Specify: White

130 Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

1 ☐ Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

Cottege (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

1 Yes 21 No Specify:

16b. Kind of Business/Industry

Elementery/Secondery (0-12)

Assembler

Electronics 18. Mother's Name (First, Middle, Maiden Surname)

17. Fether's Neme (First, Middle, Last) Oliver

Heaster

Bessie Remley

19a. Informant's Name/Reletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 "3c" Middleway Road Middle River Maryland 21220

Norma Jean Fitch (daughter)

20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Date 20c. Location - City or Town, Stete

20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify)

Gardens of Faith Cem.

1/28/99 Baltimore County, Md

ture of Furieral Service Lice

22. Name and Address of Facility Bruzdzinski Funeral HomePA 1407 Old Eastern Avenue Essex, Maryland 21221

Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ck, or heart failure. List only one ceuse on each line.

Approximete Intervat Between Onset end Death

Immediate Cause (Final disease or condition resulting in deeth)

COROMARY ARTERY DISPASE Due to (or as a consequence of)

10 YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest

Due to (or as a consequence of)

Due to (or as a consequence of):

Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

ISCHAEMIC

CULITIS

CEREBROY ADOULAN DISEASE

24b. Were autopsy findings available prior to 24e. Wes en autopsy completion of cause of death?

BREAST

CAMCER

1 Yes 2 XNo 26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of 28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

29a. Certifier

27. Manner of Death

1 Neturei

2 Accident

3 ☐ Suicide

4 Homicide

6 Could not be determined 28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one)

1 Cortifying Phyalcien: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) end menner as stated. 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) and manner stated.

29b. Signature and title of certifie

31. Dete filed (Month, Dey, Yeer)

29c. License number

29d. Date signed (Month, Day, Year)

IMD

47945

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haris

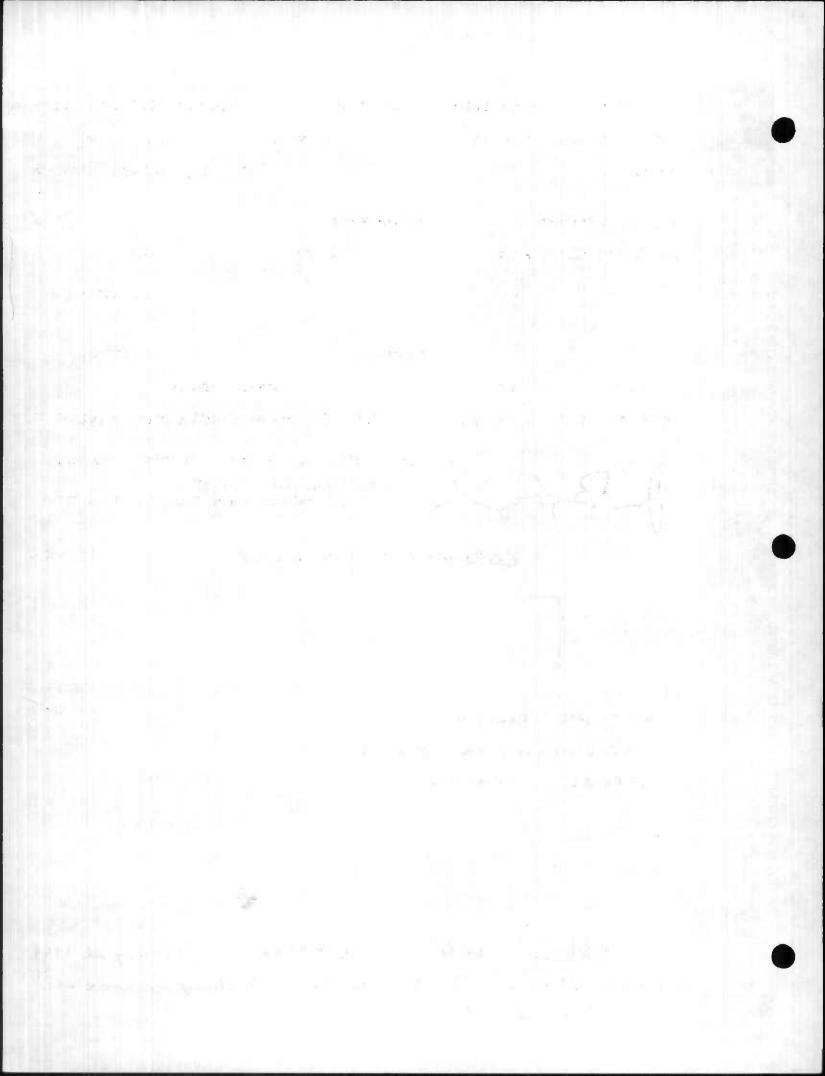
3007 32. Registrar's Signature

E. Northorn Partuay Balhmore un D

State Registrar

DHMH 16 Rav 6/95

JAN 27 1999 EEO 9 0 0000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar **Physician** HAMBY tOWARD **JANUARY** 21, 1999 9:10 AM /Medical 4a Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3805 COOLIDGE AVENUE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 110 M 2□ F Yrs Director 216-42-2343 55 RICHMOND, VA Usual Residence of Deceden 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Ves 2 □ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3805 COOLIDEGE AVENUE 21229 U.S.A. Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or Noti Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 XMarried Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4 Divorced WHITE "natural". Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Madical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12TH GRADE WORKING LEADER ALLUMINUM FABRICATING permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic event pince. 18. Mother's Name (First, Middle, Maidan Sumame) 17. Fether's Name (First, Middle, Last) STANFORD MICHAEL HAMBY LEONA MESSNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 3805 COOLIDGE AVENUE - BALTIMORE, MARYLAND 21229

20b. Placa of Disposition (Name of Date 20c. Location - City or Town, State BARBARA A. HAMBY (WIFE) ca of Disposition (Name of metary, cramatory or other place) 20a. Method of Disposition 1/22/99 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTO/WASHINGTON CREMATORY LAUREL, MD 21. Signature of Funaral Service Licensaa 22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE - BALTIMORE, MARYLAND 21229 uanuta V Momor 23a. Part I. Extar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock of haart failura. List only ona causa on aach lina. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition rasulting in daath) /Medical **Examiner** Examiner certificata be axecuted attending physician and for use as the bunal-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events rasulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of) 88 23b. Did tobecco use contribute to the cause of deeth? the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o requires that the 1 Yss 2 No 3 Probably 4 Unknown signed by م Records. p 24b. Wara eutopsy findings availabla prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed peeu The law page 2 certificate has 2E No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was casa referred to medical examiner? Be 26. Piace of Daath (Check only ona) 10 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28h Time of After t Certification: or Attending 1 Natural 5 Panding investigation 1 ☐ Yes 2 ☐ No I Director: A death. 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completaly filled in by 4 Homicide 29a. Certifier critifying Physician: To the best of my knowledga, death occurred at the time, date and placa, and due to the cause(s) and manner es steted. edicai (Check only dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 94 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 21 30. Nama and addrass of parson who compiated causa of death (Itam 23a) (Type, Print)

State
Registrar

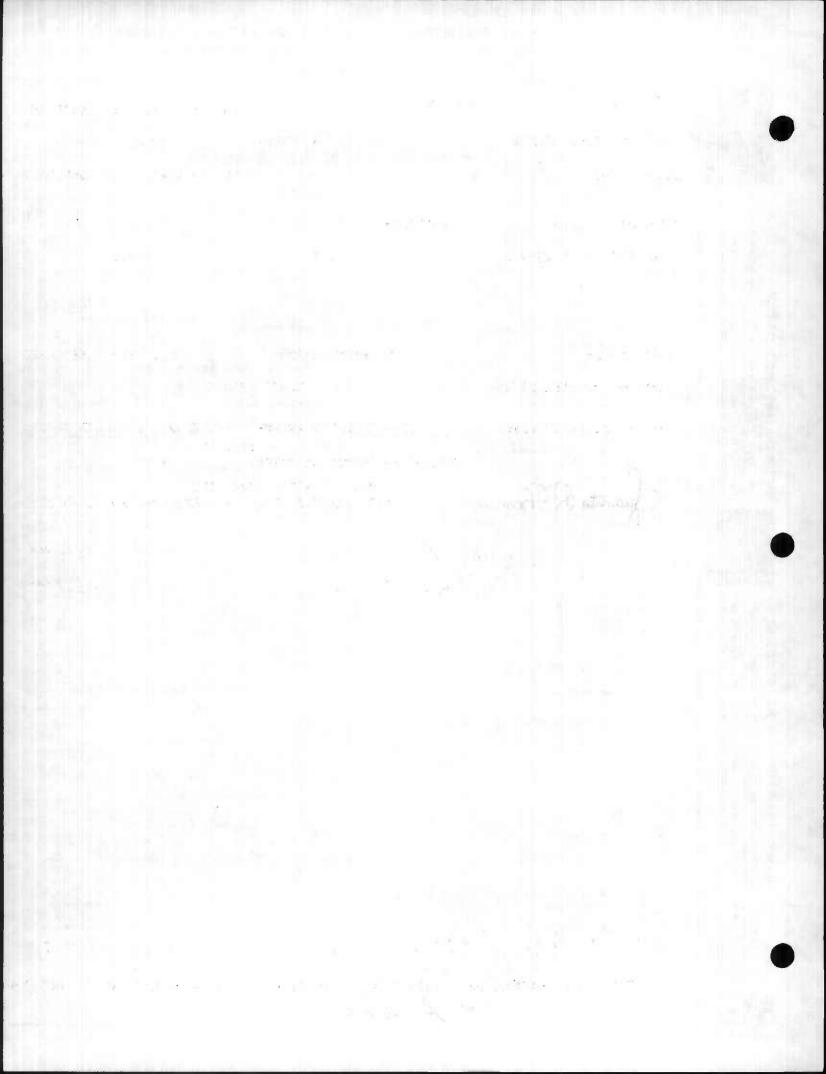
31. Date filed (Month, Day, Year) JAN 2 7 1999

WILLIAM C.

WATERFIELD - DEP

32. Ragistrar's Signature

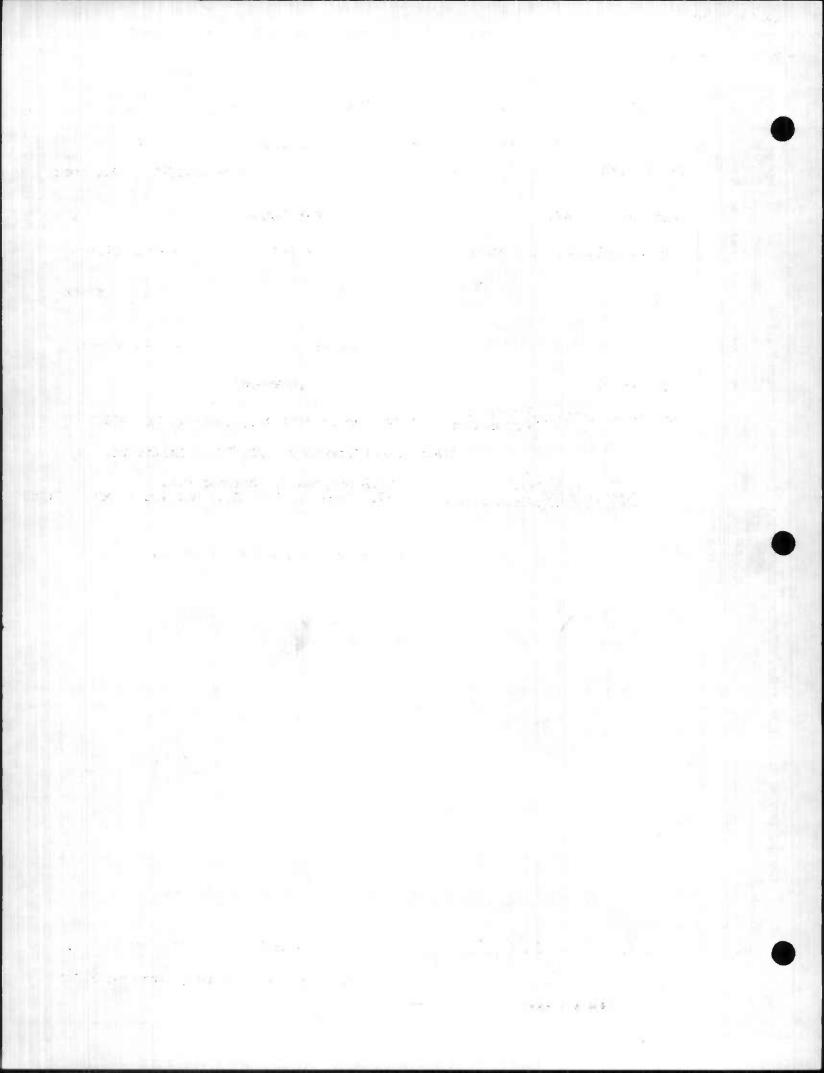
DEPARTMENT OF ONCOLOGY - 900 CATON AVE-BALTO., MD21229



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State of Maryland / Department	t of Health and Mental F	lygiene	22

## Facility Names of Prox Nathbook pies ware and number of Names of Prox						C	ertifica	te of	Death		Reg. No.				
Helen Familiary Facility Name of first including pin series and included pin series and included pin series and included pin series and including pin series and pin series an	L	_	1. Decedent'a Name (First, Middle, La	ist)						2. Date of De	ath	Veer	3. Time of Death		
## Facility News Fract inflution, par well and mumber 100, 100, 100, 100, 100, 100, 100, 10			Helen	C.			Hi1d	a					1:27 P.M.		
Social Security Number A. See Security Number A. See Security Number A. See Security Number Security Num		_	4a Facility Name (If not institution, given	re street and number)					4b. City, Town, or			y of Death			
212 14 8288 10x Course 10x Superior 10x Sup												/A			
100. Closure and humber			212 14 8288				Months			Jan. 20	y, Year) 1,1918	Coul	ntry)		
Elementary/Recondary (0-12) College (1-4or 5-) Custodian Public Schools	pue *	-	-		10c. City	, Town o	r Location					1	IOd. Inside City Limita		
Elementary/Discondary (0-12) Calego (1-4or 5-a) Custodian Public Schools	he Menyi Sa-f sho	ector							Baltimore	9			1 X Yes 2 □ No		
Elementary/Boordary (0-12) College (1-dor 5-) Custodian Public Schools	23a or 2	rai Dir		1st Floor							Unite	ed Sta	ates		
Elementary/Boordary (0-12) College (1-dor 5-) Custodian Public Schools	OLZO Ours efter decreir, or items	þ	1 Never Married 2 Married	Armed Forces? 1 Yas 2 X	Ever in U.S	S. 1				pecify Yas or No o Ricen, etc.)	Bla	ck, White,	etc.		
Public Schools Publ	72 hg	eted	15. Decedent'a E	ducetion ade completed)		16a. De	ecedent's Us	uai Occu	pation during most of wor	rking	16b. Kind of E	lusiness/In	dustry		
17 Father's Name (First, Middle, Las) 18 Nother's Pather's Name (First, Middle, Las) 19 Nating Address (Street and Number: Or Part Floure Number: Oily or Town, State, Zip Code) 19 Nating Address (Street and Number: Oily or Town, State, Zip Code) 14720 Cactus Hill Rd., Accokeek, MD 20607 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 14720 Cactus Hill Rd., Accokeek, MD 20607 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Address (Street and Number: Oily or Town, State, Zip Code) 18 Nating Add	withir than	omple	Elementary/Secondary (0-12)		5+)	`lil					Public	Sch	ools		
Curkmown Curk			17. Fathar's Name (First, Middla, Last)					18. Mother's Nar	me (First, Middle	Maiden Suma	me)			
20e. Method of Disposition of Johnson St. 20e. Method of Disposition	Vente d	10	(Unknown)						(Unknow	wn)					
20a. Rafford of Disposition of Johnson State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 22a. Part Libraria Sample Development from State Baltimore, MD 22b. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Libraria Sample Development from State Baltimore, MD 21. Suprature Dr., MD 22. Suprature Dr., Baltimore, MD 22. Suprature Dr., Baltimore	2 sho end ls me		19e. Informent's Name/Relationship	Type Print) Personal								, State, Zip	Code)		
Security			calluace A.G. Alle		ative				Hill Rd						
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Physician (Medical Examiner) Physician (Medical Examiner)	Depart Depart Import Im		> Stoly An	e Dr., E	Baltimor	e, M	D 21286								
Course (Disease or Injury Indian Indian Injury Inju	/Medical Examiner	lner	llner	liner	disease or condition	a. Ath					liovascul	far D	iscasl		Onset and Death
The state of the s	be execute cian end buriel-trans	а Ехап	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury	C	as a cor):									
1 Yes 2 No 3 Probably 4 Tinknow 24e. Was an autopsy performant? 24b. Were autopsy findings wallable prior to completion of cause of death? 1 Yes 2 No 1		Medic	that initiated events	d	Due to (or) (or as a consequence of):									
1 Yes 2 No 3 Probably 4 Tinknow 24e. Was an autopsy performant? 24b. Were autopsy findings wallable prior to completion of cause of death? 1 Yes 2 No 1	Beeth atten	clan	Part II. Other standilland and this are			.147			San la Danii	ash Did	tahaasa waa a		a the serves of death?		
25. Was case referred to medical examiner? 1	of the d by the deteched		Part II. Other significant conditions (contributing to death b	ut not resu	illing in tr	ie underlying	cause g	ven in Part I.						
25. Was case referred to medical examiner? Second Place of Death Check only one	requires the	eted by										av cc	vailable prior to empletion of cause		
25. Was case referred to medical examiner? Comparison hes be 2 ge 2	du								pa	what		,			
Section Street Section S	= F 5 6		OF Mean age referred to medical	T								1	Yes 2L No		
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury 28e. Place of Injury 3 Suicide 4 Homicide 28e. Place of Injury 6 Homicide 28e. Place of Injury 8 Home 28e. Place of Injury 9 Homicide 28e. Place of Injury 1 Home 28e. Place of Injury 28e. Time of Injury at Work? 1 Yes 2 No 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route Number, 28f. Location (Straat and Number or Rural Route	VIII sician certif irecto		examiner?	Hospital:	201	ED/Out-	-tit 201	0	thor:			has /Caasi	W. A		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21	0 5 5 5			28a. Date of Inju	iry			JUA	4 LI Nursing P				ly)		
29a. Certifier (Check only one and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b.	odling th.: Afte	100	lar en attaca tia		y Year)	Inju									
29a. Certifier (Check only one and address of person who completed cause of death (Item 23a) (Type, Print) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Check only one) 29b.	or Attar	ertifica	3 ☐ Suicide 6 ☐ Could not b	200. Place of in	ury - At ho c. (Specify	me, farm	, street, facto	ry, office		28f. Location (City or To	Straat and Num wn, State)	ber or Rur	al Route Number,		
Jennis L. Chute O.C.M.E. January 26, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute was 111 Penn Street, Baltimore, Maryland 21201	e Hospitz 24 hours e Funeral letely lille	dicai	(Check only 2 Medical Exam	miner: On the basis o	f examinet	viedge, d ion and/o	eath occurre or Investigation	d at the i	ime, date end plece opinion, death occu	e, end due to the urred at the time,	cause(s) and n dete end place	nanner es : , and due l	iteted. to the cause(s)		
Jennis L. Chutting O.C.M.E. January 26, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, up 111 Penn Street, Baltimore, Maryland 21201	To the To the Comp		29b. Signature and title of certifier				2	9c. Licar	nsa numbar		29d. Date sign	ed (Month,	Day, Year)		
30. Name and address of person wiscompleted cause of death (Item 23a) (Type, Print) Dennis J. Chute, wp 111 Penn Street, Baltimore, Maryland 21201	^		Hennis	1 Chit	4.4				O.C.M.E.		Januar	y 26,	1999		
			_ //		death (Item	23a) (Ty		enn		Baltimor					
			31. Date filed (Month, Day, Year)		ar's Signal	ture	III P	CIII	outeet, I	YIT CHIKIT	c, raty	LUIKI	ZIZUI		



certificate be executed pue physicien the signed by t certificate Attending Physician: death. Director: or A To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b

Physician

/Medical

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Certification: To

(Check only one)

29b. Signature and title of certifier

EUGENE

Funeral

Director

'natural', or flams 23s or

semil. Pages 1 and 2 should be Department of Health and Mental reportant: If Item 27 is marked o

Physician /Medical

DHMH 16 Rev 6/95

State Registrar

1999

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30. Name and addrass of person who completed causa of death (ttem 23a) (Type, Print)

OBAH 32. Registrar's Signature

6565 N. CHARLES

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar as stated.

Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

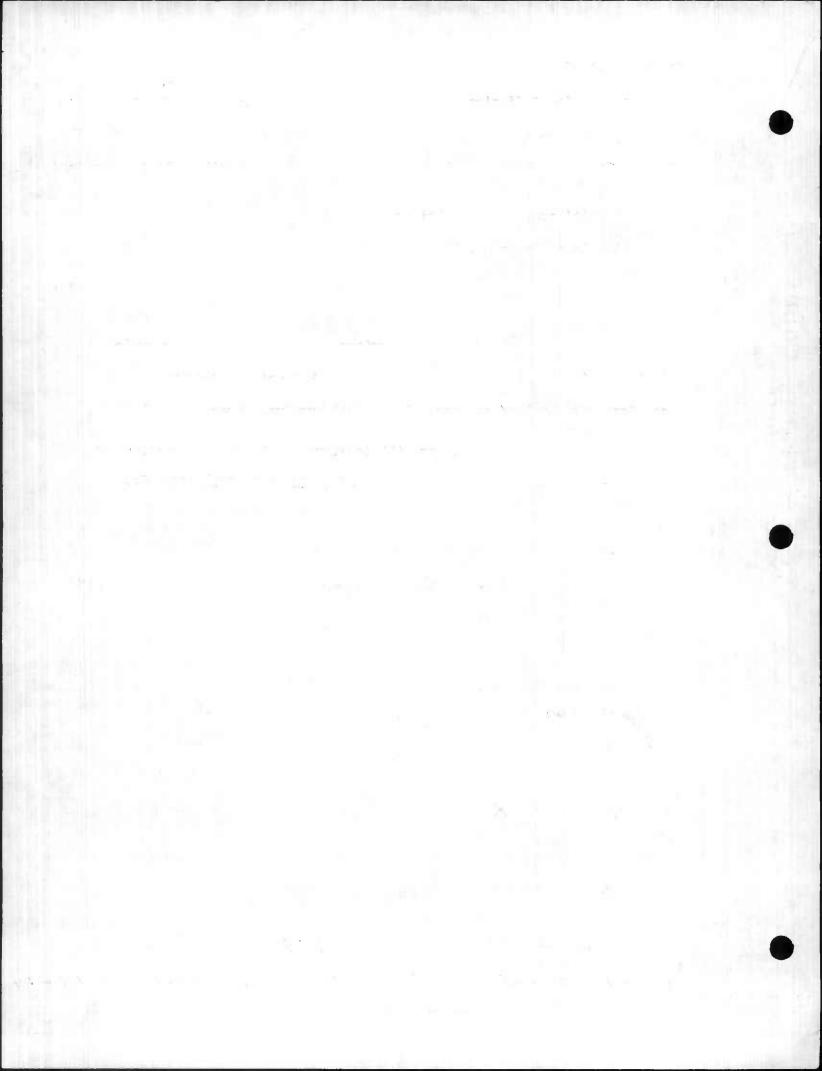
29c. License number 29d. Date signed (Month, Day, Year)

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BALTIMORE

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в.	K.S RRY ANDER	Please	State of Mary 3 PART I, 27 28	land / De						ble. 0 8	84
		1. Decedent's Name (First, Middle, L		A-F	erunca	le or	Deam	2. Data of De		101	Fima of Death
	Physician	The second secon						Month	Day	Yeer	
	/Medical Examiner	JERRY ANDERSON JAMES 4a Fecility Name (If not institution, give street and number) 603 SOUTH ANN STREET APT. 315 BALT:						JAN. Location of Death		of Death	244 PM
100	Funeral Director	5. Sociel Security Number 8. 212-78-0513	Sex 1	yrs. last birthd	Months	er 1 Year Days	H Under 24 Hrs Hours Min.	(Month, De	N / F		Stete or Foreign
	D	Usuel Residence of Decedent	once of Decedent								
	ahow adam or	10a. Stete 10b. County	10	BALTII							side City Limits
	frer deeth with the Ma r hems 23a or 28a-f s instrmust be notified Funeral Director	MD. N/A		DALIII		ip Code			10g. Citizen of \		
		603 S. ANN STR	EET APT. 315	. 1	101. 2	212:	21				
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Maryland th and Mental Hyglena. 7? Is marked other than "natural", or items 23e or 28e-f show theumatic event, the Medical Essenting must be incitited at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Wes Decedent Ever Armed Forces? 1 ∑ Yes 2 ☐ No If Yes Giva	in U,S. 1	3. Wes Dec If Yes, sp	edent of H	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	U.S.A 14. Rad Bled Specifi	ce - Amarican Ind ck, White, etc.	lien,	
00	d by	3 Widowed 4 Divorced	Year or Detes: 197							WHITE	
21215-0020 d within 72 hours of gions. or than "natural", or fre Wederl Enem	led within 72 ho lygiena. Nor than "natura nt, pre Medical Completed	15. Decedent's (Specify only highest g	College (1-4or 5+)	(G	cedent's Us ive kind of w e. DO NOT RPENTE	ork done use retired	during most of wo	rking	CONSTRI	usiness/Industry	
0	Hod Hygid	17. Fether's Neme (First, Middle, Las	ot)	CAI	KPENIE	Ж	18. Mother's Na	me (First, Middle			
Maryland	Mental H Mental H Mrked out artic even	JOSEPH ANDERS	ON JAMES				ILENE	BERNICE	McCAULI	FY	
ary	2 should end Men la marke eumatic	19e. Informent's Neme/Reletionship		19b. M	ailing Addre	ss (Street	and Number or R)
Baltimore, N	pemil. Pages 1 and Department of Health Important: If Nem 27 eny Injury or other tr once.	SUSAN JAMES/WIFE 20a. Method of Disposition 1 Burial 2 Deremetion 3 4 Donetion 5 Other (Spec	Removel from State	0b. Place of Di	sposition (Noremetory or JNT CE 22. Name a	eme of other place METER and Addre		Date 3/99	BALTIMO	MARYLAN City or Town, S ORE, MARY	tete
	40200	Maddelle	I Church		1901 E	ASTER	RN AVENUE	E. BALTIM	ORE, MD.	21231	
	Physician /Medical Examiner	23a. Pert1. Enter the disease, or co- shock, or heart feilure. List onl Immediate Cause (Final disease or condition resulting in death)	a. DRU	G (DOXEPI	N) INTO	XICAT		c or respiratory a	rrest,	Inter	oximete val Between at and Death
o,	an and unial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying									
0x 6876	death certificate be e strending physicis of for use as the bu sician/Medical	Cause (Disease or injury that initieted events resulting in death) Last	C. Due	to (or as a con-	sequence of):				l l	
, P.O. Box	y the charter	Part II. Other significant conditions	contributing to death but no	t resulting in th	e underlying	cause giv	en in Pert I.		tobacco use co Yes 2 No		
Records,	2 00 C		-5						en eutopsy ormed?	evailable	ion of cause
	The law ate has pege 2							1/2	Yes 2□No	12 Ves	2 No
Vital	certificats rector, per	25. Wes case referred to medical					26. Place of De	eth (Check only	one)		
>	2 00 2	examiner? XX Yes 2 □ No	Hospitel: 1 Inpatient	2 ER/Outpa	tient 3 [Oth Oth	er: 4 Nursing I	Homa ŞOXResi	dence 6 Oth	ner (Specify)	
0	de de set	27. Manner of Death 1 ☐ Netural 5 ☐ Pending	28a. Dete of Injury (Month, Day Yea	ar) 28b. Tim		28c. Injur Wor			how injury occur		
Sio	Attending in death. ector: After by the funation:	2 ☐ Accident investigeti	on 1-21-99	12:30	М	10	Yes 2 No		INGESTED		
Division of	ital or Attending Phars after death. ral Director: After thi lied in by the funaral Certification: 7	3 Suicide 6 Could not 4 Homicide determine	building, etc. (S	At home, ferm, pecify) OME ADDRE		ry, office		281. Location (City or To	Street and Number, Stete) 603	Per or Rural Rous	TREET,
	Hospi 24 hou Funer Funer stely fill		thysician: To the best of my iminer: On the basis of exa end menner steled.								;euse(s)
	Me Me	29b. Signetura end fitte of certifier			2	9c. Licens	e number		29d. Date signe	d (Month, Day,	Year)

To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu

BALTIMORE, MD. ABOVE HOME ADDRESS 29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number

O.C.M.E

JAN. 22, 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Strollen S. R 31. Date fled (Month, Day, Year) JAIN & 7 1944 Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 26 Per PHY Film G767 1-27-99 rja Certificate of Death 3. Tima of Death 2. Dete of Deeth 1. Decedant's Name (First, Middle, Last) noth **Physician** 130 mES na /Medical 4b. City, Town Examiner tree 81 Yrs. If Under Months **Funeral** 1 NZM 2 TE Days Director with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examples and the notified at once. Town or Location 10d. Inside City Limits 1 EYes 2 No Funeral Director noR 10f. Zip Code 10g. Citizan of What County 12 12. Was Dacadent Ey Armad Forcas? 1 Yas 2 D No If Yas, Giva Yaar or Datas; onic Origin? (Specify Yas or No-Maxicen, Puarto Rican, atc.) 14. Race er in U.S 13. Was Dacedant of H if Yas, specify Cube Black, White, 1 Nevar Married 2 Married 1 Yas 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) condary (0-12) Collaga (1-4or 5+) Nere Maidan Suma 17. Fathar's Nama (First, Middla, Last) 18. MON ar's Nama (First, Middla Be 10 SIE 0 ino nber or Rural Routa Ni Placa of Disposition (Nama of cematary, cramatory or other place) d of Disposition 1 Burial 2 □ Cramation 3 □Re rom State 4 ☐ Donation 5 ☐ Othar (Specify) MOR 0 21. Signature of Funaral Sarvice in 22. Nama and Addrass of Fac Edmondson -10 Approximata Intarval Batween Onsat and Daath 23a. Part1. Entar tha disaasa, or complications that caushock, or haart failura. List only ona causa on aad d the deeth. Do not anter **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burlal-tran Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consaquance of) Division of Vital Records, P.O. Box 68760. that initiated avants Due to (or as e consequence of) rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. After this certificate has been signed by the funeral director, page 2 should be datached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy ic Obstantive Pulmonary 1 Yas 2 No 20 No 1 Yas or Attending Physician: Be 25. Was cesa rafarrad to medicel 26. Placa of Daath (Chack only ona) axaminari Yas 2□ No Other: 4 Nursing Homa Hospital: 1 Inpatiant P 5 Rasidance 6 Othar (Specify) 3□ DOA 28c. Injury at Work? 27. Manner of Daath 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 5 Panding Invastigation Natural death. 1 Yas 2 🗌 No 2 Accident Director: / 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 3 Suicide 6 Could not ba 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) aftar 4 Homicida within 24 hours aft To the Funeral Dis completely filled in Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29a. Cartifian Medical and mannar statad.

29c. License number

latad causa of daath (Itam 23a) (Type, Print)

32. Registrar's Signatura

29d. Data signed (Month, Day, Year)

Jan., 25,

, MO

State Registrar 29b. Sign

in and titla of certifia

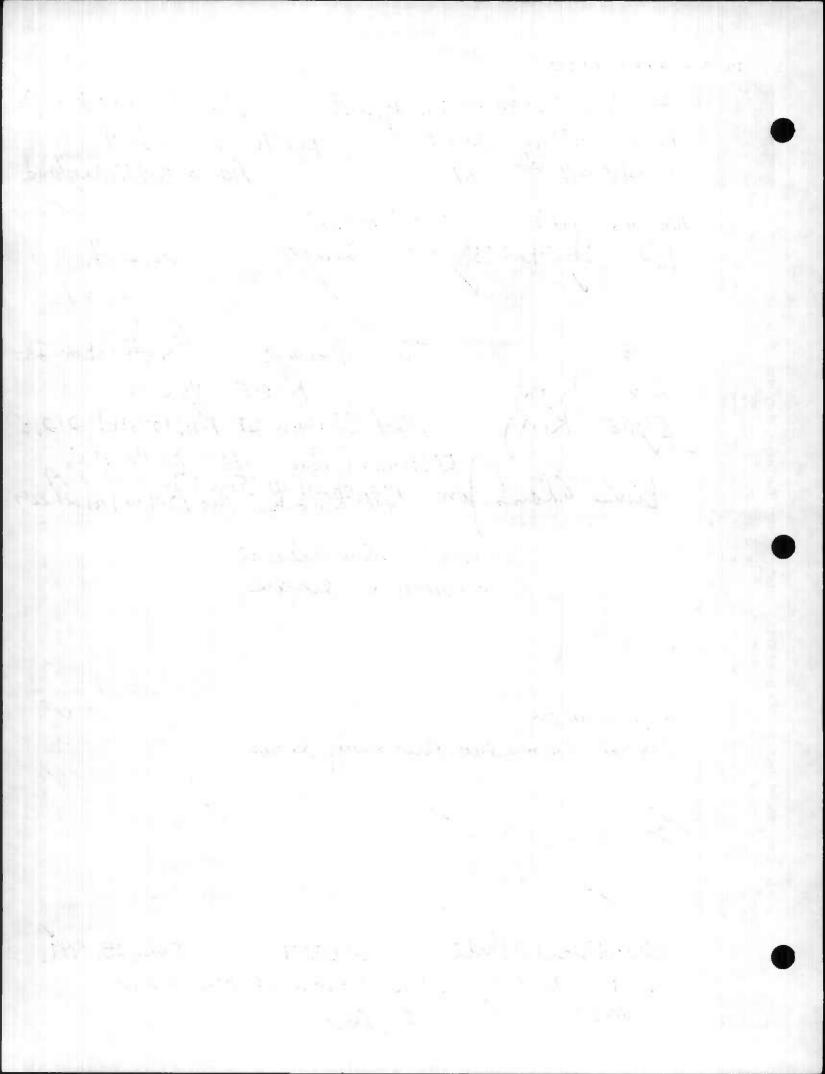
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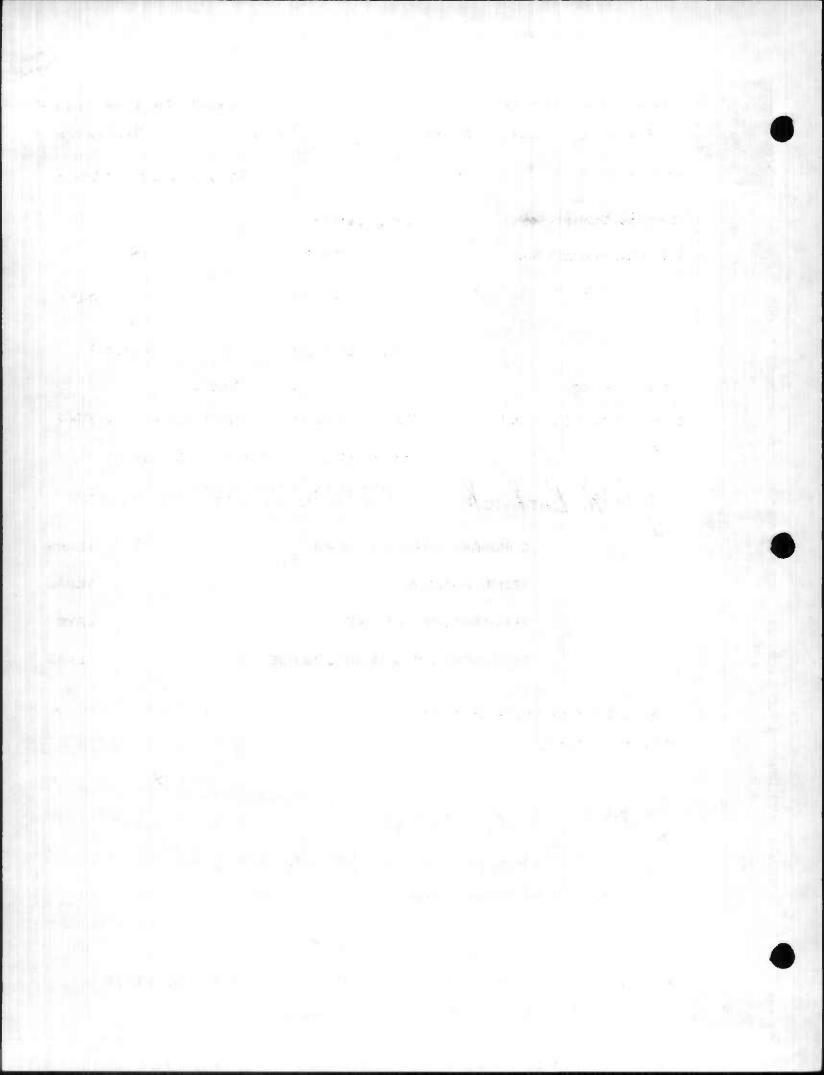
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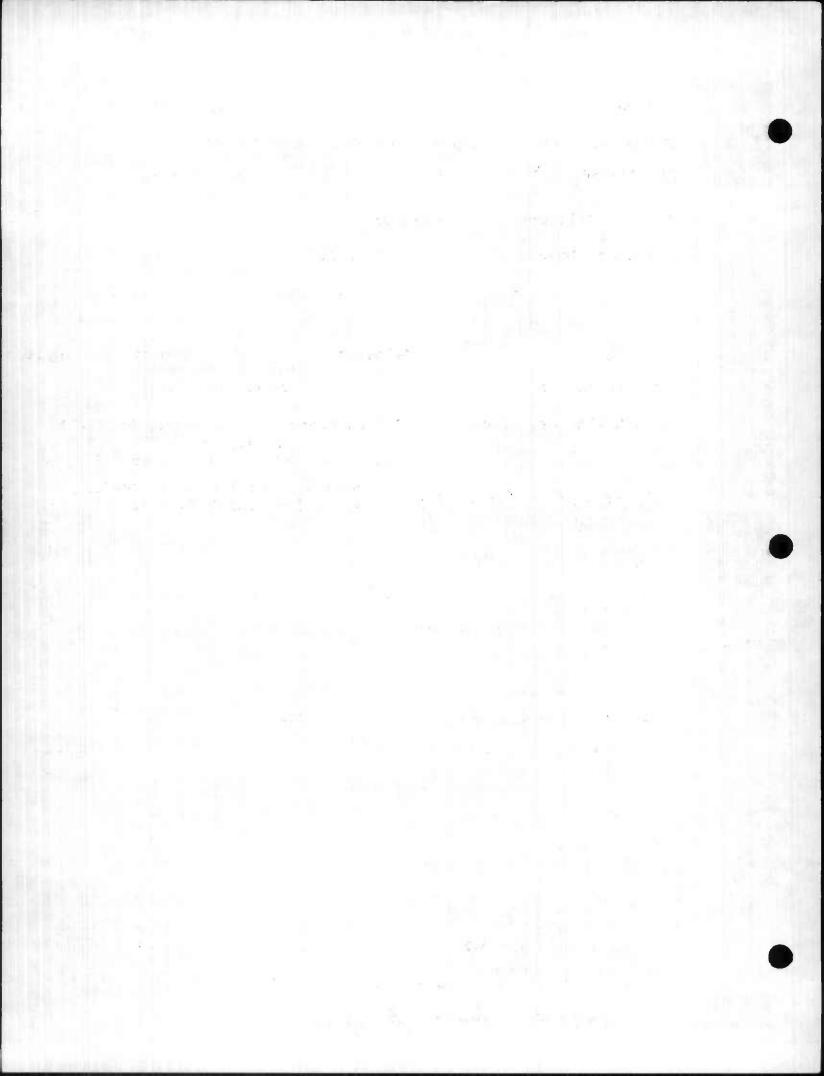
	1. Decedent's Name (First, Middle, La	st)				2. Date of Death			ime of Death			
cian lical	ANDRA CAROL K	EYSER				JANUARY			03 PM			
ner	4a Fecility Neme (If not institution, give Saint Joseph				4b. City, Town, or Lo		4c. County	of Death altimo	re			
al or	210 42 4010	ex 7. Ag	ge (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Aug. 2:			Stete or Foreign			
	Usual Residenca of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Ins	alde City Limits			
0	Maryland Harford			ettsvill	۵				Yes 2 No			
Funeral Director	10e. Street and Number		July	10f. Zip Code		10	g. Citizen of V	Whet Country?				
a D	1116 Sharon Acres	Rd.		210	84		US	SA				
	11. Marital Status 1 Never Married 2X Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 Xi If Yas, Give Year or Dates:	No	Vas Decedent of I f Yes, specify Cub I ☐ Yes 2 🕱 No	Hispanic Orlgin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americen Ind ck, White, atc.				
De	15. Decedent's E		16a. Deced	lent's Usual Occu	pation	1	16b. Kind of Bi	usiness/Industry				
Completed by	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or :	5+1	kind of work done 00 NOT use retire cal Tech	pation during most of work nd) nician	ing		spital				
2	17. Father's Neme (First, Middle, Last Alvin Anderson				18. Mother's Nam Mildred	Roberts		ne)				
	19a. Informant's Name/Relationship (Edward Keyser (Hu	***			end Number or Run							
	20a. Method of Disposition 1		20b. Place of Dispo cometery, crer Gardens	netory or other ple				City or Town, Store, Md.				
	22. Name end Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221											
	23a. Path Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or raspiretory arrest, in ck, or heart feilura. List only one ceuse on each line.											
	Immediate Cause (Final disease or condition resulting in deeth)	CDRONARY ARTERY DISEASE Pue to (or as a consequence of):										
nine		RENAL	FAILURE					YE	ARS			
edicaj Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events	RESPIR	Due to (or as a consec ATORY FAI					DA	YS			
dica	Ceuse (Disease or Injury that initiated events resulting in death) Lest	C	Due to (or as a conseq	uence of):								
		d. PERIPH	ERAL VASC	ULAR D	ISEASE		YEAR		ARS			
sicia	Part II. Other significant conditions of	ontributing to death b	out not resulting In the u	nderlying ceuse gi	ven in Pert I.	23b. Dld to	bacco uae co	ntribute to the c	ause of death?			
by Phy	PARALYSIS DUE TO					1 🗆 Ye	s 2 No	3 Probably	4 Unknown			
Completed by Physician/M	LUPUS ANTICOAGULE	ENT				24e. Was ai perform		24b. Were au available completi of death?	prior to on of ceuse			
Com						1 □ Ye	s 25 No	1 🗆 Yes	213KN0			
Be	25. Was cese referred to medical exeminer?	Develop				th (Check only on	e)					
2	1 ☐ Yes 2X No	Hospital: 1 Inpatie		I 3 DOA		ome 5 Reside						
edical Certification:	27. Manner of Death Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be		ey Year) Injury	M 1	Yes 2 No	28d. Describe ho			to Alice have			
Certif	4 ☐ Homicide determined	building, et	jury - At home, farm, str ic. (Specify)			28f. Location (St. City or Town	, State)		e /vumber,			
edical	29a. Certifier (Check only one) 1 Certifying Pt	yalcian: To the best niner; On the basis o and menner st	of my knowledge, death of examination and/or in ated.	vestigation, in my	opinion, death occur	red at the time, da	ate and place,	and due to the c				
2	29b. Signature and title of certifier	Liuthic	mn min	29c. Licen D3188	se number 26	29		od (Month, Dey, 1	Year)			
-	30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) RICHARD LINTHICUM, M. D., 76@1 YORK ROAD, TOWSON, MARYLAND 212@4											



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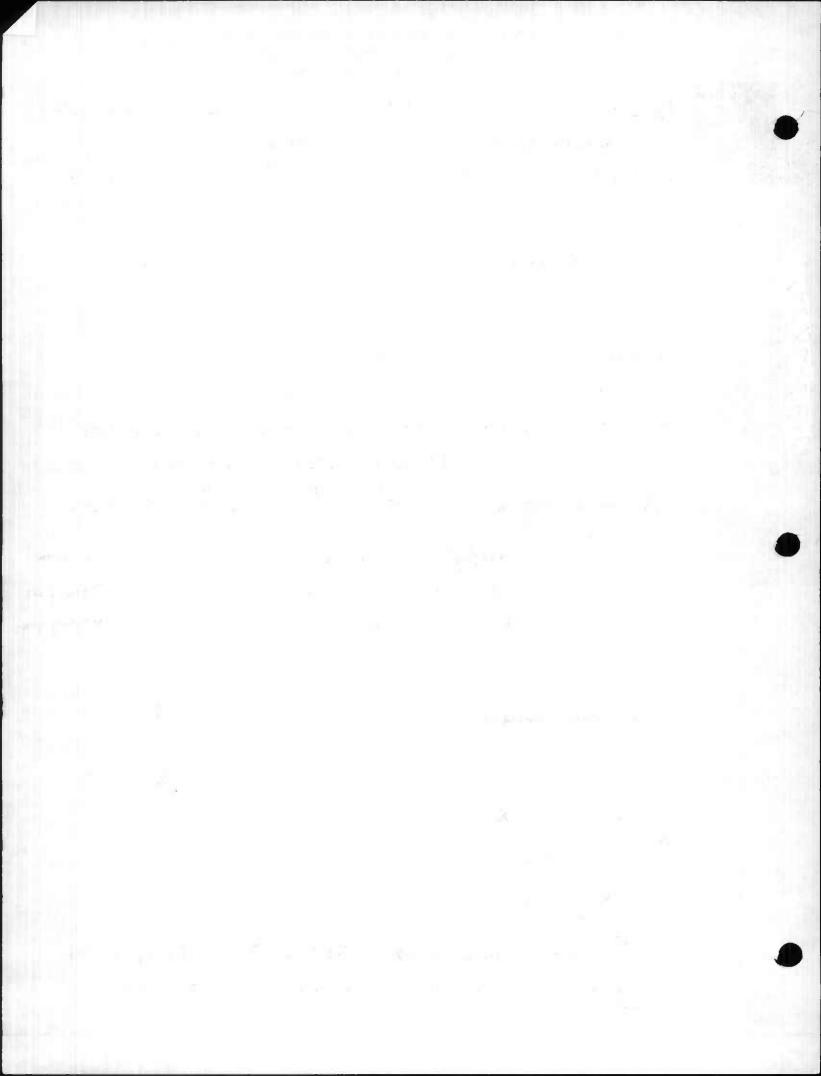
State of Maryland / Department of Health and Mental Hygiene

				001111100	ate of i	50000		Reg. No.		
	1. Decedent's Name (First, Middle,	Last)		1/ 11		0	2. Date of De	eth Day	Year	3. Time of Death
hysician	John H	+		Kelle	-	Sr.	JANUAR		1999	1:20 A1
/Medical xaminer	4a Facility Name (If not institution, g	give street and number)			4	b. City, Town,	or Location of Deat	h 4c. Count	ty of Death	
	JOHNS HOPKIN	5 BAYVIE	W MI	EDKAL C	TR.	BALT	IMORE	N/	A	
neral		. Sex 7. Age			der 1 Year	If Under 24 H	rs. 8. Dete of Bir in. (Month, De	th v. Year)	9. Birthp	place (State or Foreig
ector	216-42-9302	1X3 M 2□ F	53	Yrs.	la Days	710010		1945	MD	,
	Usual Residence of Decedent 10a, State 10b, County		10a City	Town or Location					1	0d. Inside City Limits
ector				Town or Location						1 ☐ Yes 2 ØN
rector	MD Balti	lmore	Ea	lgemere	-					
Dir.	10e. Street and Number				Zip Code			10g. Citizen of	What Cour	ntry?
ral	5 Barbara Lar				2121		40	USA	an Amada	an Indian
dical Exercise results notified etclor	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	Armed Forces?	1X Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify:				(Specify Yes of No erio Rican, etc.)	Speci	ace - Americ ack, White, ify: Wh	
ted	15. Decedent's (Specify only highest (Education		16a. Decedent's U	sual Occup	ation duning most of	vorkina	16b. Kind of I	Business/Inc	dustry
To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)			duning most of s				
Comp	10			Salesm	an					l Suppli
Be C	17. Father's Name (First, Middle, La						lame (First, Middle		ıme)	
To age	Francis Kelle	er					erine S			
	19a. Informant's Name/Relationship			19b. Mailing Addr	ess (Street	and Number or	Rural Route Numb	er, City or Town	n, State, Zip	Code)
any injury or other treumatic event, tra Ma once. To Be Comp	John Keller J	r. /son		7700 B				mere,		
r ot	20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3	□Removal from State	20b. Pla	nce of Disposition (i	Name of or other plac	ce) Cem.	Jan 28	20c. Location	n - City or To	own, State
nry o	4 Donation 5 Other (Spe		Gar	rison F	ores	t Vet.	1999	Owing	s Mil	lls, MD
ician dical niner	Immediate Cause (Final disease or condition	a. Seps	. ' c						1	. 1.
as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	o. pnevi	Due to (or and or and o	as a consequence of the transfer of the transf	or de	ficercy	2			53 year: I week
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Registrar



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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth **Physician** Month OBERT LEEKVIST /Medical 4e. Fecility Name (If not Institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner y) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Days Hours Min. Feb 20 1925 HAUEN 6. Sex Nursina Co OREST 0 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country)
 PA **Funeral** M 2□F 179-07,800 Vrs Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show must be notified at Director MD Baltimore City Yes 2 No Baltimore City 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 3628 Old York Road 21218 USA "natural", or items 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Tyes 2 No
If Yes, Give Korean
Year or Detes: Korean 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☑ Divorced Completed permit. Pages 1 and 2 should be filled within 72 inportant: If flem 27 is marked other than 'neturn plury or other traumatic event 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) Collage (1-4or 5+) Short Order Cook Edgewood Diner 4th 17. Fether's Neme (First, Middle, Lest) 18. Mothar's Name (First, Middla, Malden Surnama) Ivor E. Kvist Mabel Elizabeth Hoover 19a. informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Steta, Zip Coda) 198 Black Gap Rd, Lot 129, Fayetteville, PA 17222 Linda Elkins (sister) 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State 1-25-99 Catonsville, MD MetroCrematory 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licensei 22. Name end Address of Fecility Dean P Charlton 2007 Eastern Ave, Baltimore, MD 21231
23e. Pert1. Enter the discome, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximately appr Approximete intervel Between Onset end Deeth **Physician** immediate Cause (Final disaasa or condition resulting in daath) /Medical Premonia Examiner Dua to (or es a consequance of): Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Entar Undarlying Causa (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician sthe buriel P.O. Box 68760, Physician/Medical Due to (or es a consequence of): signed by the aid be deteched for Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24b. Were autopsy findings aveileble prior to completion of ceuse of deeth? 24e. Wes en autopsy page 2 certificate 1 Yes 2 No 1 ☐ Yes 20 No Division of Vital or Attending Physician: funeral director, 25. Wes cesa referred to medicel examiner? Be 26. Place of Daeth (Check only ona) 1 Yes 2DANO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Home Medical Certification: To 5 ☐ Residence 8 ☐ Other (Specify) 27. Magner of Death 28e. Dete of injury (Month, Dey Year) 28b. Time of injury 28d. Describe how injury occurred 28c. injury et Work? 1 Naturat 2 ☐ Accidant 5 Panding invastigation efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 4 Homicide To the Hospital within 24 hours e completely filled 1. Certifying Physicien: To the best of my knowledge, deeth occurred at the time, deta and piece, end due to the causa(s) end menner es stated.
2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, deta end piece, end due to the causa(s) end manner stated. 29e. Cartifian (Check only one) 29b. Signeture and title of certifier 29d. Date signed (Month, Dey, Year) Taymond Mella D47683 30. Name end address of person who completed ceuse of deeth (item 23e) (Type, Print) SUITE 2 00 REISTESTOWN 25 MILLER MAINE RAYMOND STREET 31. Dete filed (Month, Dey, Yaer)

JAN 2 7 1999 32. Registrer's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item:11 per F.H G-768 2/1/99 reb Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Day LILLIAN MC LEOD 23 1999 7:16PM 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST NURSING CENTER TOWSON BALTIMORE If Under 24 Hrs. Birthplace (State or Foreign Country) MARYLAND If Under 1 Year 8. Date of Birth (Month, Dey, Year) 8 26 51 5. Social Security Number 7. Age (In vrs. lest birthdev) Min Months Days Hours 1□M 200 216-54-4731 47 Usual Residence of Deceden 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 10b. County XXYes 2□ No MARYLAND NZA BALTIMORE 10e Street and Number 10f Zip Code 10g Citizen of What Country? 5005 WEST HILLS ROAD 21229 IIS 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2XNo If Yes, Give Year or Dates: or Married 200 Married 1 ☐ Yes XXNo Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SUPERVISOR GOVERNMENT 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOHNNIE FOREMAN MARY PRYOR 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 5005 WEST HILLS RD. BALTIMORE, MD 21229 JOHN McLEOD (HUSBAND) 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 X Suriai 2 Cremetion 3 Removal from State GARRISON FOREST VET. 1/27/99 OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility PHILLIPS FUNERAL HOME PA. Decto CFSX 1721-27 N. MONROE ST. BALTIMORE, MD. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final OVAVIAN CANCEY disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy 1 Yes 2 No 1 Yes 2 No 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined

The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital or Attending Physician: Hospital

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Ne Funeral Director: A plataly filled in by the f plataly within 2

Physician

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r than "natural", or items 23s or 28s-f show

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Department of Health and Mental Hygis Important: If Item 27 Is marked other

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31. Dete filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and hie of certified

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28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and piece, end due to the cause(s) and menner stated. 29d, Date signed (Month, Dev. Year)

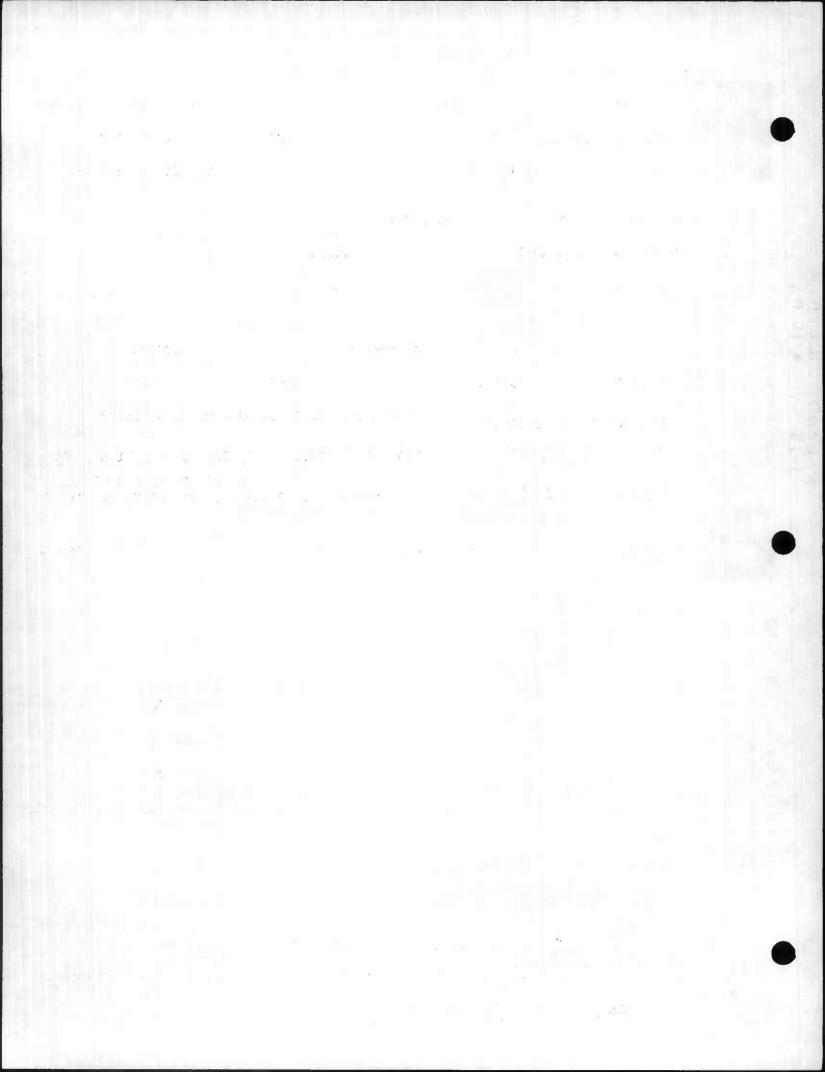
30. Name and eddress of person who completed cause of death them 23a) (Type, Print) Riley VG

N. Charles St. BMC

BALL.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

32. Registrar's Signature JAN 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1 Decedent's Name (First Middle Last) Genesis Eder CATE Baltimore CITY n/a

7. Age (In yrs. lest birthday)

H Undar 1 Year It Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. 8. Date of Birth **Physician** Thomas James Mason 1999 · /Medical 4c. County of Deeth 4e Fecility Nama (If not institution, give street and number) Examiner MAnor JATON n/a Birthplace (Stata or Foraign Country) 5. Sociel Security Number **Funeral** 150 M 2□ F 213-26-9726 Director July 10, 1930 Md. Usuel Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Md. 1 Yes 2 No n/a Baltimore Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? with is marked other than "natural", or items 23a or traumatic svent, the Medical Examiner must be 4637 Manordene Road Apt. C 21229 USA Funeral deeth 12. Wes Decedent Evar in U,S. Armad Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Race - Amarican Indian. 11. Maritel Status Black, Whita, etc. Pages 1 end 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Merchant Seaman National Maritime Union 12th Grade 18 Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middla, Last) James Leggett Blanche V.Mason 19a. Informent's Neme/Reletionship (Type, Print) Wife 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Naomi G. Mason 4637 Manordene Road Apt. C Baltimore, Md. 21229 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stata 20e. Method of Disposition Important: If it any injury or o Buriel 2 Cremetion 3 Removel from Stata 4 Donation 5 Other (Specify) Garrison Forest Veterans Jan. 29 Owings Mills, Md. 22. Nama end Address of Fecility 21. Signature of Funerai Service Licenses Nutter Funeral Homes, Inc. derver 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat end Deeth **Physician** Acute Cevebrovarculer Accedent wede Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Examine physician and the bunal-transit the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events rasulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): 98 attending p Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the detached religionarcular 4) Unknown 1 Yes 2 No 3 Probably þ 24b. Were autopsy findings evailable prior to 24e. Wes an eutopsy performed? Completed completion of causa of death? i certificete hes b irrector, page 2 s 2 X No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only-one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation Natural 1 Yes 2 No 2 Accident within 24 hours after deeth To the Funeral Director: , completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated. edicai (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and mannar stated. To the within 2 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number Altenday Doda Wegwee M1 121684 1-25-199

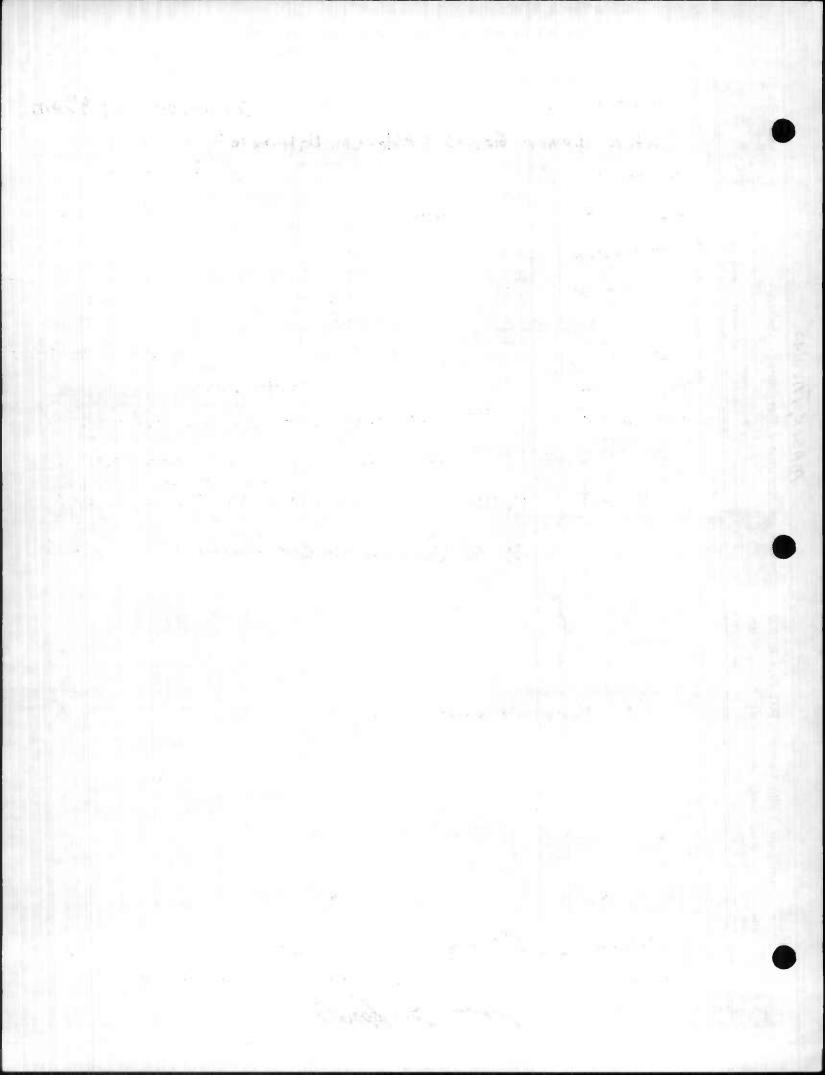
State Registrar C.V. CTRIAC. M.D SIDG RITCHIE KNY, 32 Registrer's Signeture

PASAORNA

30. Name end address of person who completed cause of deeth (item 23e) (Type, Print)

31. Dete filed (Month, Dev Year) 1999

nAsca, Thomas



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day Month **Physician** PRESTON MURRAY JANUARY 23 1999 · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner NA BAUTIMORE BAUTMORE VA MEDICAL CENTER 8. Data of Birth (Month, Day, If Undar 1 Yaar If Undar 24 Hrs. Birthplace (Stata or Foraign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** 18 M 2□ F Days Hours Min 212 20609 Usual Rasidence of Dacedanf Yrs. **Director** 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Heelih end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any injury or other thaumatic event, the Medical Example man be notified as 1 Yes 2 No MOR Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Funeral Was Decedant Evar in U.S. Armed Forcas?

1 Yas 2 No 1957

1 Yes, Giva
Yaar or Datas: 195 Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Race - Amarican Indian 11. Marital Status Black, Whita, atc. 1950-1 Navar Married 2 Married 1□ Yas 2□ No Specify: Baltimore, Maryland 21215-0020 by 3 Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry LABORER Elementary/Secondary (0-12) College (1-4or 5+) 6 d 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Top 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) MILLARED 57 BATTMORE 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata BALTIMORE 29/99 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL 21. Signature of Funaral Sarvice Licansas 21. Part 1. Entar the diseasa, or complications that ceusad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MORL M Approximate Interval Batwean Onset and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) KIDNEY FAILURE 3 weeks Examiner Physician/Medical Examiner CONGESTIVE HEART FAILURE attending physicien end for use as the burial-tren Sequantially list conditions, if any, laading to Immadiata ceuse. Enter Underlying Cause (Disease or Injury Dua to (or as a consequance of): certificate be axed Division of Vital Records, P.O. Box 68760, that initiated avants rasulting in death) Last Dua to (or as a consaquanca of): 23b. Did tobacco use contribute to the ceuse of death? Part II. Other eignificant conditions confributing to death but not rasulting in the underlying ceusa givan in Part I. 3 Probably 4 Unknown 1 Yes 2 No Chronic Obstructive Pulmonary 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed page 2 28 No 1 Yas 2 No 25. Was cese rafarred to medicel axaminar? Be 26. Placa of Daath (Check only ona) To Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA After this 28b. Time of 28d. Dascribe how injury occurred Certification: 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 2 Accidant 5 Pending Invastigation 1 ☐ Yas 2 ☐ No death. eftar death 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 ☐ Homicide 6 24 hours 1 Cartifying Phyeician: To the best of my knowledga, daath occurred at the time, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medicai

To the F within 2

State Registrar

29b. Signatura and titla of certifian

MARK BENVAMIN 31. Data filed (Month, Day, Year)
JAN 27 1999

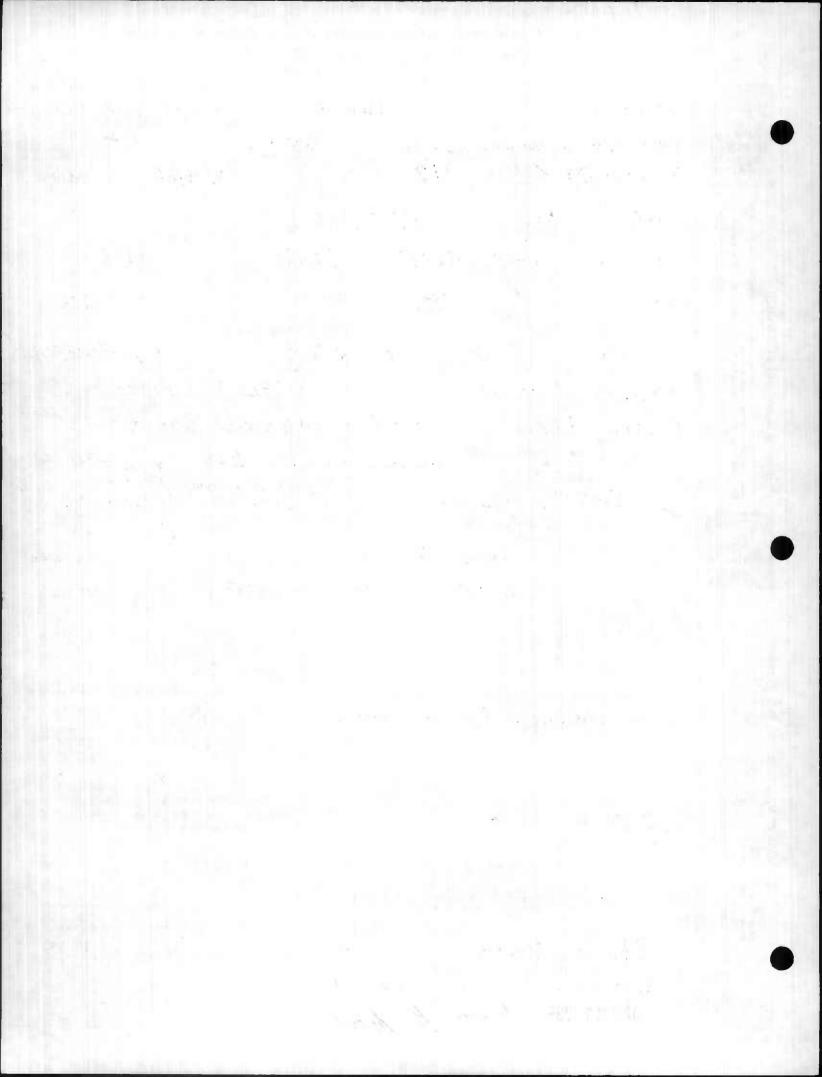
30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

32. Registrar's Signatura

29c. Licansa number

M.D

29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Time of Death Day Kathleen M. Nine January 25, 1999 11:25 am 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4508 Fieldgreen Rd. Perry Hall Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foraign Country) 1□M 2♥F Months Days Hours Min 218 84 2692 38 Yrs. Aug. 1,1960 Maryland Usual Rasidance of Decedan 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 3541 Dahlia Lane 21220 USA 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 14 Race - American Indian. 11. Marital Status Black, Whita, etc. 1 Navar Married 2 Marriad 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) College (1-4or 5+) Elementery/Secondery (0-12) Baltimore Schools Bus Driver 18. Mothar's Nama (First, Middle, Maidan Sumama) 17. Father's Nama (First, Middle, Last) Kathleen Kuhns Theodore Markowski 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) John Nine (Husband) 3541 Dahlia Lane Baltimore, Md. 21220 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 XBuriai 2 Cramation 3 Ramovai from Stata Holly Hill Mem. Gardens 1/28/1999 Baltimore, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221 234 Port. Entar the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, block, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Extensive small cell lung cancer Immediata Causa (Final disaasa or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaasa or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Due to (or as a consequance of): 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was en eutopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 TYAS 2K No 1 ☐ Yes 2 ☐ No 25. Wes cesa rafarred to medical axaminar? 26. Place of Death (Chack only ona) Othar: 4 Nursing Homa 5 Rasidence Sister's Residence 1 TYAS 2 NO 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Daeth 28b. Tima of 28c. Injury at Work? 1 X Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 4 Homicide

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Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Haalth and Mental Hygiene. Important: if item 27 is marked other than "natural", or then any injury or other traumatic event, the Hadical Epartment

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/Medical **Examiner**

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Certification:

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29a. Certifiar

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altimore, Maryland 21215-0020

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Box 68760 P.O. Division of Vital Records, or Attending after death. à A 24 hou. The Funeral Dis-Hospital within 24 hou To the Fune completely fi

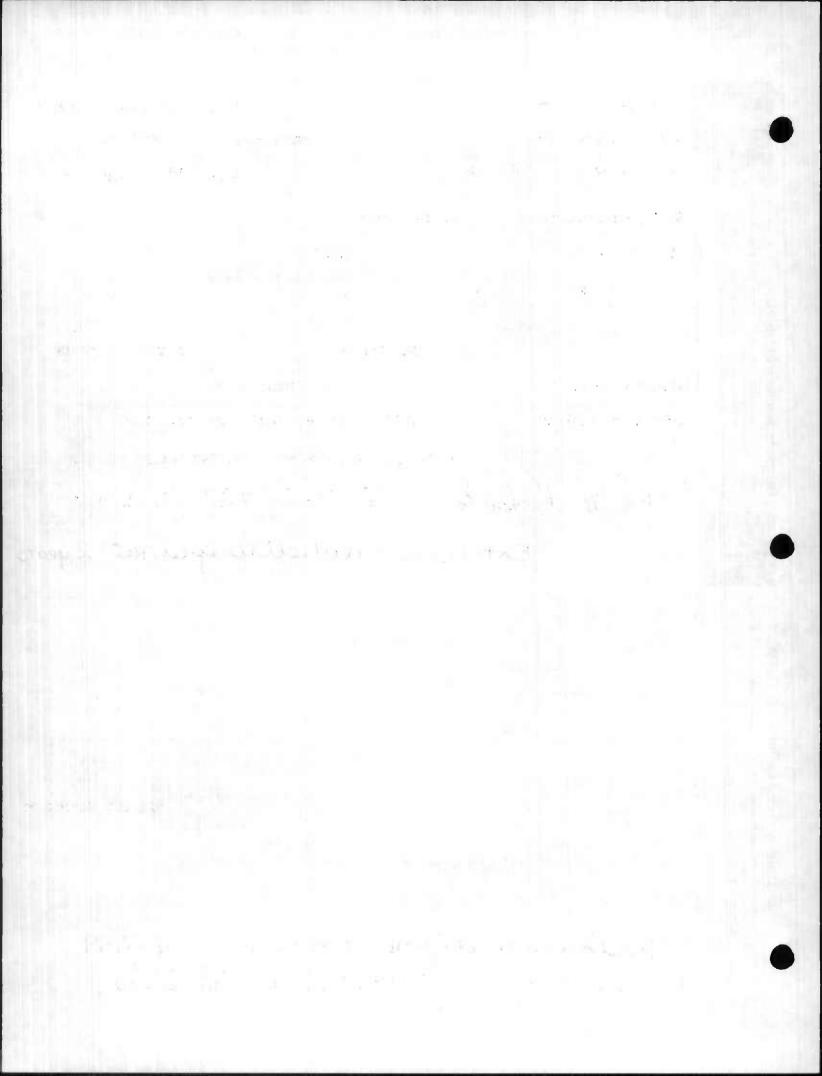
State Registrar 152 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Chaudly MD

29c. License number

29d. Date signed (Month, Day, Year) 1/27/99

30. Nama and addrass of parson who completed ceusa of daath (Itam 23e) (Type, Print) SQUARE DRIVE MADHU CHAUDHRY 9000 FRABALINORE MD 21237 1999^{32. Registra s Signatura}

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State of Maryland / Department of Health and Menta

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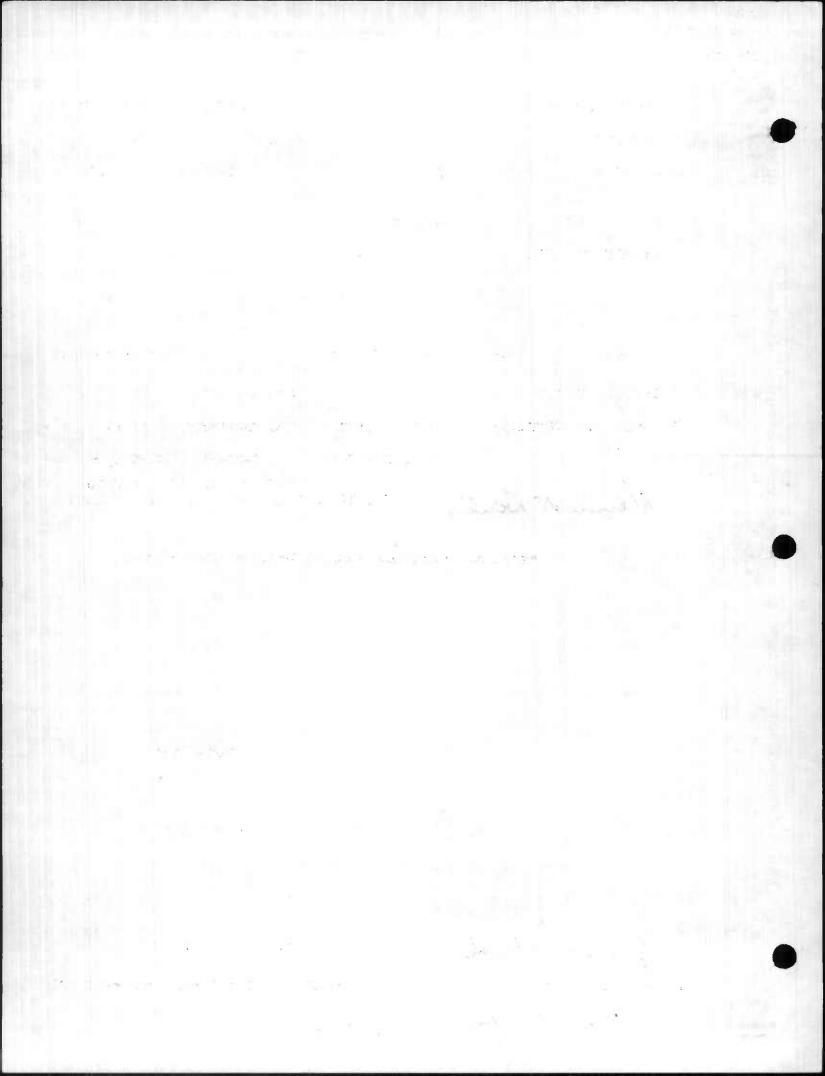
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4	/Medical Examiner	4e Facility Neme (If not institution, given	ra straat end numb	oer)			4b. City, T	own, or L	ocation of Death	4c. County	of Deeth	
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	Funeral Director	5. Social Security Number 6. 8 240–32–6245	Gex I□M 2☐F	Age (In yrs. I		If Under 1 You Months Da		Min.	8. Data of Birt (Month, Der 1-30-	X Year)	9. Birthple Count N • (ece (Steta or Foreign (A) •
н	_	Usuel Residence of Decedent										
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	vith the Mar 1 or 28a-f al 2 notified Director	10e. Street and Number				10f. Zip Cod			10g. Citizen of	Whet Count	try?	
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	72 hours efter death with the Maryland neturel, or fleme 23e or 28a-f show deal Examiner must be notified at each by Funeral Director.	11. Merital Stetus	12. Wes Deced	as?	S. 13. W	as Decedent Yes, specify (of Hispenic C Cuban, Mexic	origin? (Sp an, Puerto	ecify Yes or No- Rican, etc.)	14. Rec	ce - Amarica ck, White, a	
20	urs eft.	1 Never Marriad 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give Yaer or Det	21	1	□ Yes 2Å	No Specif	y:		Specif	y: BLACI	K
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Maryland		RICHARD SIMPSO	N				.TF	ESSTE	HASSEL	ſ.		
an	S DE E	19a. Informent's Neme/Reletionship			19b. Mailing	g Address (St			el Route Numbe		, Stete, Zip	Code)
	D5N5	RICHARD SIMPSON(NEPHEW)		4222	RIDGEW	OOD AV	/E. B.	ALTIMOR	E, MD 2	1215	
Baltimore,	200	20a. Method of Disposition	Demouslifus Ct		lace of Dispos em <i>etery</i> , crem	etory or other	f place)		Dete	20c. Location	- City or To	wn, Stete
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alt	permit. Ped Department Important: Important: any Injury o	21. Signature of Funerel Sarvice Lice	nsaa	1	22.	Neme end A	ddrass of Fac	ility VER	NON R. I	BATLEY	FUNER	AL SERVICE
	Physician /Medical Examiner	shock, or heert feilure. List only Immadiate Ceuse (Finel disease or condition resulting in death)	Hyperte	nsive <i>l</i>	Arterio		tic Ca	rdio	vascula	r Disea	se	Intervel Between Onsat and Death
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Division	tal or Attending P rs after death. al Director: After t led in by the funer. Certification;	3 Suicide 6 Could not be determined	200. PIECE 0	Injury - At ho , etc. (Specify	ome, farm, stre	eet, fectory, of	lice		281. Location (Street end Number or Rural Route Number, City or Town, Stete)			
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	within 2 To the comple	and menner stetad. 29b. Signature and little of certifler					canse numbe	r		29d. Data sign	ed (Month, i	Day, Yeer)
	F 3 F 8	10 am loste MD					O.C.M.E.			JANUARY 26, 1999		

State Registrar

J. Laron Locke M.D. 31. Data filed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 29 230 KM Genevieve Margaret O'Brien 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) N/A St. Elizabeth Nursing Home Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | June 24 1911 9. Birthplece (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 X F Yrs. 132-01-5616 87 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 MYes 2 □ No 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 3320 Benson Ave 21227 USA 14. Race - American Indian, Bieck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2 Merried White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) William Wise Mary E. Curry 19e, informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8400 E. Charles Valley Ct. Towson, MD. 21204 Sr. Kathleen Mary O'Brien/Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Suriei 2 ☐ Cremetion 3 ☐ Removal from State 1-27-99 Oueens, NY. Calvary Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name and Address of Facility Riick Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete interval Between Onset end Deeth immediate Ceuse (Final disease or condition resulting in death) CEPSIS Due to (or es e consequence of):

JRINARY TRACT INFECTION Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest ALLITE ON LHKONIC RENAL PAILUKE NEEDS Due to (or as a consequence of) DEHYDRATION EVERE 23b. Did tobacco use contribute to the cause of death? Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown EMENTA 24b. Were eutopsy findings evallebie prior to 24e. Wes en eutopsy performed? completion of cause of deeth? e No 1 Yes 1 Yes A PUNO 26. Place of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. injury et Work? Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Examiner Box 68760. Division of Vital Records, P.O.

Physician/Medical þ Completed 89

To

Certification:

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Examine

physician 941 8 957 signed by 8 ate has i or Attend after death Director: within 24 hours To the Funeral

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

of filed within 72 hours after If Hygiene. other than "naturel", or ite

2 should be fi and Mental H is marked off

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum page.

Physician /Medicai

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Saltimore, Maryland 21215-0020

the Maryland

death v

25. Wes case referred to medical examiner?
1 Yes No

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and placa, end due to the cause(s) end menner steted.

29b. Signeture end title of cartified

29e. Certifier (Check only one)

29c. License number

29d. Dete signed (Month, Dey, Year)

use of deeth (Item 23e) (Type, Print) MORE

State Registrar

32. Registryn's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 896 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death JANUARY **Physician** 2/34 01,1999 INA PHILLIPS /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner GEORGES HOSPITAL CENTER PRINCE GEORGES PRINCE CHEVERLY Hours Min. 8. Data of Birth (Month, Day You Dec. 3) If Undar 1 Yaar 9. Birthplace (Stata or Foreign 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Year 1926 Hardin, TX Months Days 1 M 2 XX 72 452-30-8234 Director Usual Rasidance of Decedant with the Maryland 10a Stala 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow edical Examper must be notified at Indiana 1 Yas ZONo Director Kosciusko Leesburg 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 46538 239 East Levi Lee Road IISA permit. Pages 1 and 2 should be filed wittin 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedant Evar in U,S. Armed Forcas?

XX Yas 2 □ No
If Yas, Giva
Yaar or Datas: 1946 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian 11. Marital Status Black, Whita, atc. 1 Navar Married 2 Married White Baltimore, Maryland 21215-0020 1 Yas 2KNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collaga (1-4or 5+) Empolyee Printing Company 18 Mothar's Nama (First Middla Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Eugene Fregia Emma Doucette 19a. tnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Galen Phillips / Husband 239 East Levi Lee Road, Leesburg, Indiana 46538 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Jan 1 Burlal 22 Cramation 3 Ramoval from Stata 1999 Akron, Indiana 4 ☐ Donation 5 ☐ Othar (Specify) Hoosier Crematory 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility McHatton-Sadler Funeral Home 2290 Provident Court, Warsaw, Indiana 46580 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata intarval Batwe Onsat and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in daath) riviedreal · MULTIPLE INJURIES WITH COMPLICATIONS Examiner Dua to (or as a consequanca of) Examiner physician end the buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that Initiated avants rasulting in death) Last Dua to (or as a consaguance of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) 80 980 signed by the e 23b. Did tobacco use contributa to the cause of death? Part fl. Other afgnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings availabla prior to complation of ceuse of death? should 24a. Was an autopsy performed? Completed s certificate has b director, page 2 s 1 ☐ Yas 2 ☐ No director, Attending Physician: 25. Was cesa rafarrad to medical axaminar? 26. Placa of Daath (Check only ona) Be axamınar? 1 N Yas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant 2 □ ER/Outpatient 3 □ DOA Certification: To this funeral 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred PASSENGER OF AUTO VS TRUCK 27. Mannar of Death 28b. Tima of 28c. Injury at Work? After 1424 1 Natural 5 Panding 12-18-98 1 Yas 2 No death. invastigation 2 Accidant COLLISION after death Director: / I in by the f 6 Could not be datarmined 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) Location (Straat and Number of Bural Royte Number, NCity or Town, Stata) 4 Homicida ò 198 & RUSSETT GREEN RD • Funeral Di letely filled in STREET KOUTE 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medical completely (Check only one) within 2 To the I 29b. Signatu 29c. Licansa number 29d. Data signad (Month, Day, Year) DME use of death (Item/23a) (Type, Print) 30. Nema and addrass of person who compl

MD

32. Registrar's Signatura

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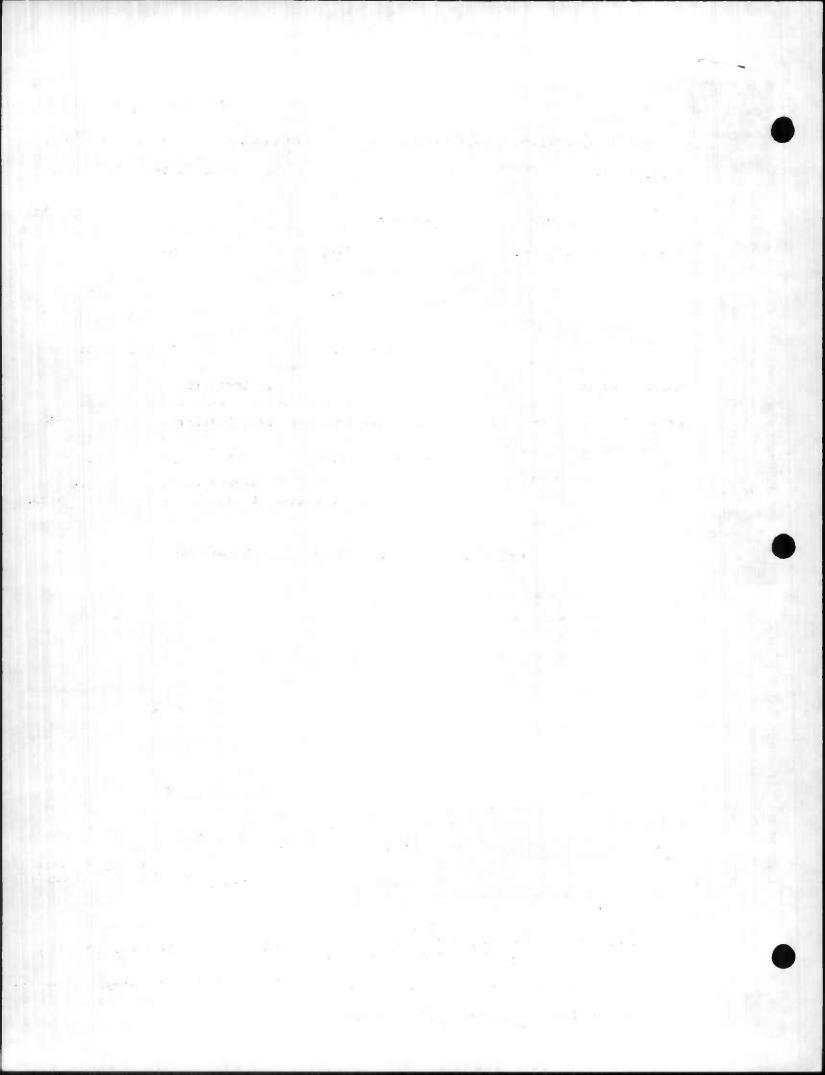
HOSPITAL PRIVE, CHEVERLY

JK

MARYLAND 20785T

State Registrar MARIO

31. Data filad (Month, Day, Year)



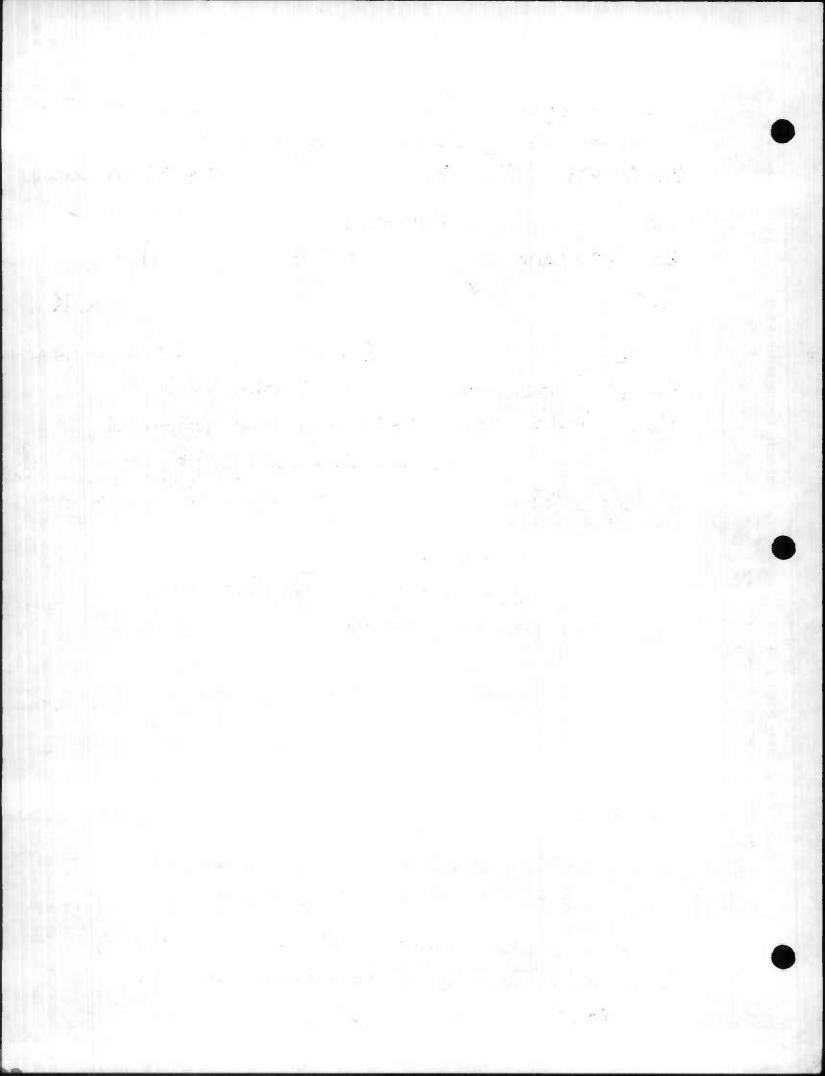
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 640 AM **Physician** Parker anuary 22, 1999 Gr wendolyn /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner HOSPITAL GENERAL MARYLAND Baltmore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 M 20 Months Days Hours 218 · 20 · 4633 New -Director with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "naturel", or frems 23a or 28a-f ebov traumatic event, the Magical Experient must be notified at 1 Yes 2 No Daltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 2316 KoKO 238 Funeral death 12. Was Decedent Ever in U,S.
Armed Forcas?

1 Yes 2 No
If Yes, Give
Yaar or Dates: 14. Race - American Indian, Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status Black, Whita, etc. filed within 72 hours efter 1 Never Married 2 Married 'naturel', or 1 Yas 2 No Black Specify 3 Widowed 4 □ Divorced Aq Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Baltimore Cacher City Public Sal 18. Mother's Name (First, Middle, Maiden Surname) permit, Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if Item 27 is marked ofth any linjury or other traumstic event Rada. 17. Fathar's Name (First, Middla, Last) Sanford 1010 Danie 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) 20c. Location - City or Town, State arles 316 KOKO Vance Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Baltimore 1.1-26-99 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licensee JERF Miller 639 North 23a. Part Linie the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or hear failure. List only one ceuse on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) neumonia Examiner with decreased Peripheral Prefusion Physician/Medical Examiner certificate be axecuted attanding physician and for use es the buriel-trensit Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760, Dua-to (d 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Was an autopsy Completed The lew cartificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or Attending Physicial within 24 hours after death.
To the Funeral Director: After this ca 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28e. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 HomicIde 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medicai 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11828 MP delle 30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) Maryland General Hospital. m.D. 9/0 Kasha Morad 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Ray 6/95

Registrar

JAN 2



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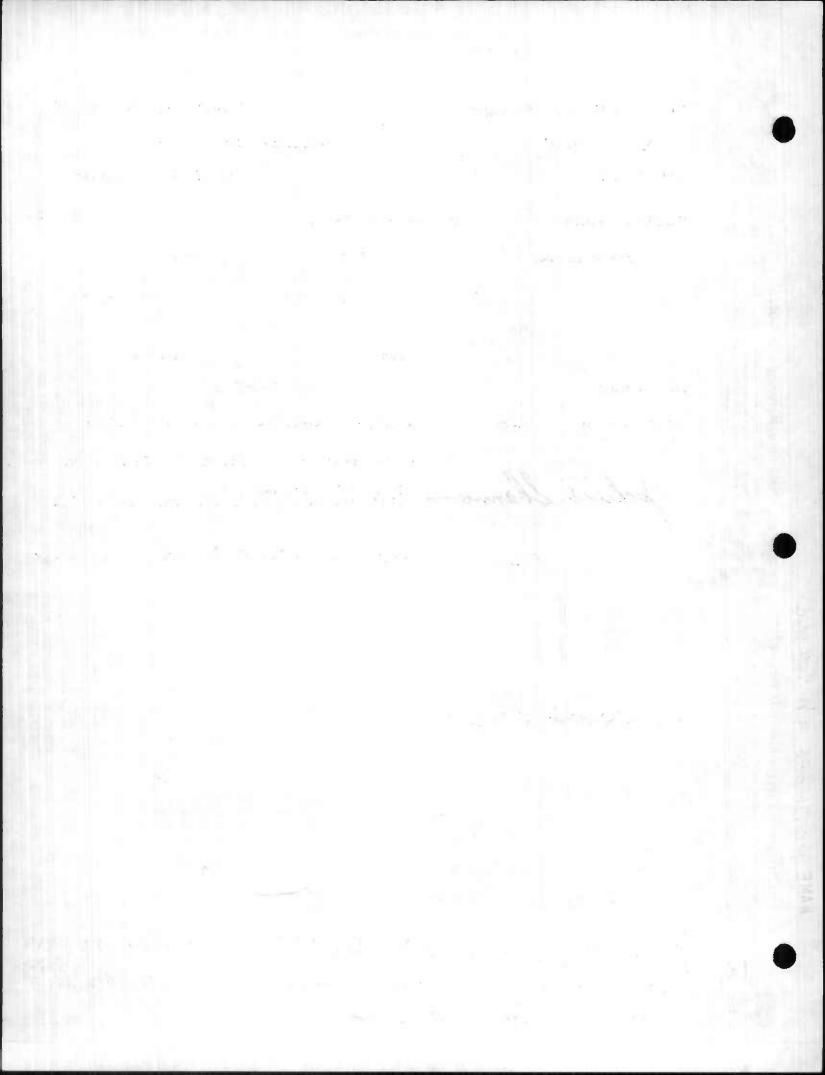
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 21, **JANUARY** 1999 21:40 Catherine Theresa Pittinger · /Medical 4b. City. Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) **Examiner** St. Agnes Hospital Baltimore City n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours Min 1 ☐ M 2 🖺 F Yrs **Director** 220-03-2327 June 27, 1914 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Moulcal Examiner must be notified at with the Maryler 1 Yes 2 No Directo Maryland Baltimore Baltimore Highlands 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2806 Vermont Avenue 21227 USA Pages 1 and 2 should be filed within 72 hours aftar death vent of Health and Mentel Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: White by 3 ☐Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 9 Homemaker Ownhome 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) John Wimmer Anna Deuschel 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Nancy A. Green / Niece 5316 Dogwood Road, Woodlawn, Maryland 21207 other 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) ò permit. Page Department of Important: If any Injury or poce. Glen Haven Cemetery 1/25/99 Glen Burnie, Maryland 22. Name and Address of Fecility Hubbard Funeral Home, Inc. Vart1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** ial in Earction Immediate Cause (Final disease or condition resulting in deeth) /Medical acute muocard Examiner Due to (or as)e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): usa as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy performed? page 2 certificata has 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel exeminer? 26. Piece of Deeth (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide To the Hospital
within 24 hours of To the Funeral Completaly filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as atated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a, Certifie Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier completed cause of death (Item 23e) (Type, Print)

OUNDES GOO CATON AUGULE BACKMORE, Maryland . Neme and eddress of person woo 75000'L 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 7 1999 Registrar

AME PITTINGER, CATHERINE



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State of Mary

land / Department of Health and Mental H	ygiene
Certificate of Death	Bea No

	1
Physician	
/Medical	L
Evaminar	4

1. Decedent's Name (First, Middle, Last)

2. Dete of Death			3. Time of	Death
JANUARY	23,	1999	3:20	PM.

N/A

DOUGLASS E. PENIX la Facility Name (If not institution, give street and number)

SHOCK TRUAMA

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Deeth

Funeral

PENNIX

5. Social Security Number M 20 F 213-84-3108 Usual Residence of Decedent

If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Deys Months Hours 8-30-74

Birthplaca (State or Foreign Country)

Director

Нета 23а

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The filem 27 is marked other than "natural, or the ury or other thaumate avent, the Mental Entirie ury or other thaumate avent, the Mental Entirie.

Baltimore, Maryland 21215-0020

death

10b. County

10c. City, Town or Location

MD 10d. Inside City Limits

10a. State mast be nothing at

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

by

Completed

Be

10

Certification:

edical

N/A BALTIMORE XXYes 2 □ No

10e. Street and Number

10f. Zip Code 21213

Yrs.

7. Age (In yrs. last birthday)

10g. Citizen of What Country?

USA

11 N. BROADWAY

11. Marital Status Never Married 2 Married

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

Black, White, etc. BLACK

14. Race - American Indian,

3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12)

College (1-4or 5+) -0-

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) SUPERVISOR

16b. Kind of Business/Industry

LUMBER

-12-17. Father's Neme (First, Middle, Last)

DOUGLASS E. PENIX SR

18 Mother's Name (First Middle Maiden Sumame)

JOYCE PENDERGRASS

19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

MARILYN RAWLINGS (AUNT) 20a. Method of Disposition

P.O. BOX 76856 WASHINGTON, D.C. 20013

20b. Place of Disposition (Name of cametery, crematory or other place)

Dete

20c. Location - City or Town, State

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

MT. ZION CEMETERY

1-30-99 BALTIMORE, MD

21. Signature of Funeral Service Licenses Decth CFSY critica

22. Name and Address of Fecility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each fine.

Physician /Medical Examiner

physician and s the burial-transit certificate be executed

attending p 950

94 signed by t

has **page 2**

certificate

this

permit. Page Department of Important: If any injury or pnce.

Immediate Cause (Final disease or condition resulting in death)

Multiple	aunshot	wounds
Due to (or es a	copsequence of):	

Due to (or es e consequence of):

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last

Pert ff. O	ther significant c	onditions contri	buting to death	but not resulting	in the underlying cause	given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

Approximete Interval Between Onset and Deeth

LE Yes 2 No

26. Place of Death (Check only one)

1. Yes 2□ No

25. Was case referred to medical examiner? 1⊠Yes 2□ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending -23-99 investigation

28b. Time of Injury 1415

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 TYes 2 No

28d. Describe how Injury occurred

29a. Certifier

6 ☐ Could not be determined 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) Sidewalk

Subject was Shot 281. Location (Street and Number or Rural Route Number, City or Town, Stele) 500 Robert 51 rect 5) dewalk Baltimore City, Maryland

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end menner as stated. Baltimore

(Check only one) 29b. Signature and title of certifier

27. Menner of Death

1 Natural

2 Accident

3 Suicide

42 Homicide

29c. License number O.C.M.E.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and pleca, end due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) JANUARY 24, 1999

de up 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radentz

Strphrn S.
31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

1999

32. Registrer's Signeture

ORIGINAL

of Vital Division

Box 68760

P.O.

Records,

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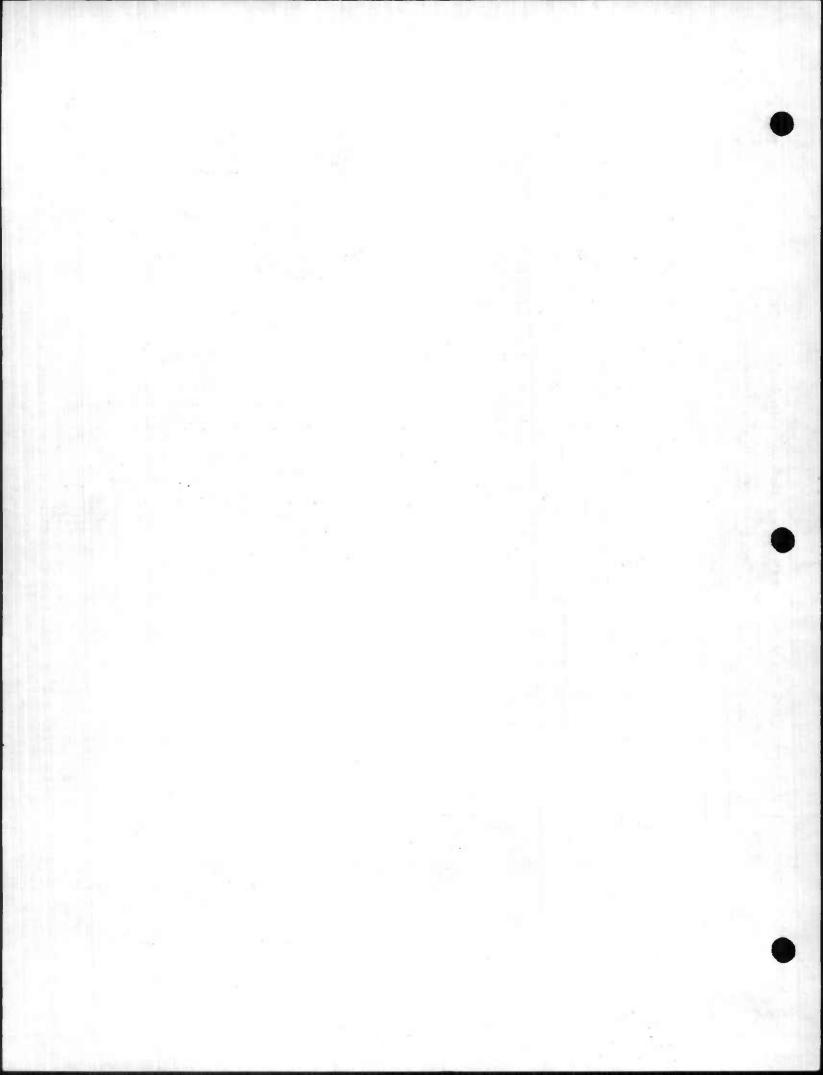
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or Attanding

Hospital

death.



D 15504

Timonium, Md 21093

2300 Dulaney Valley Rd

State Registrar

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31. Data filed (Month, DayA Nav) 2 7 1999 32. Registre's Signeture

Eddie Nakhuda, M.D.

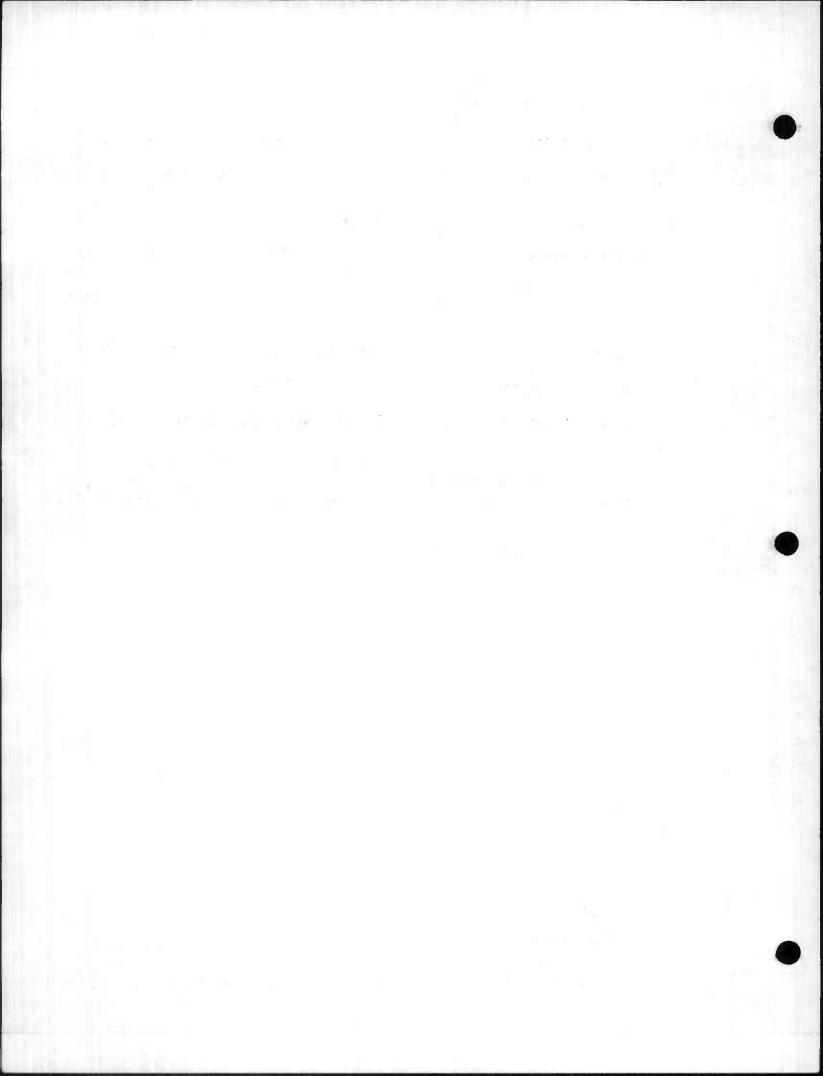
30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

JOHN

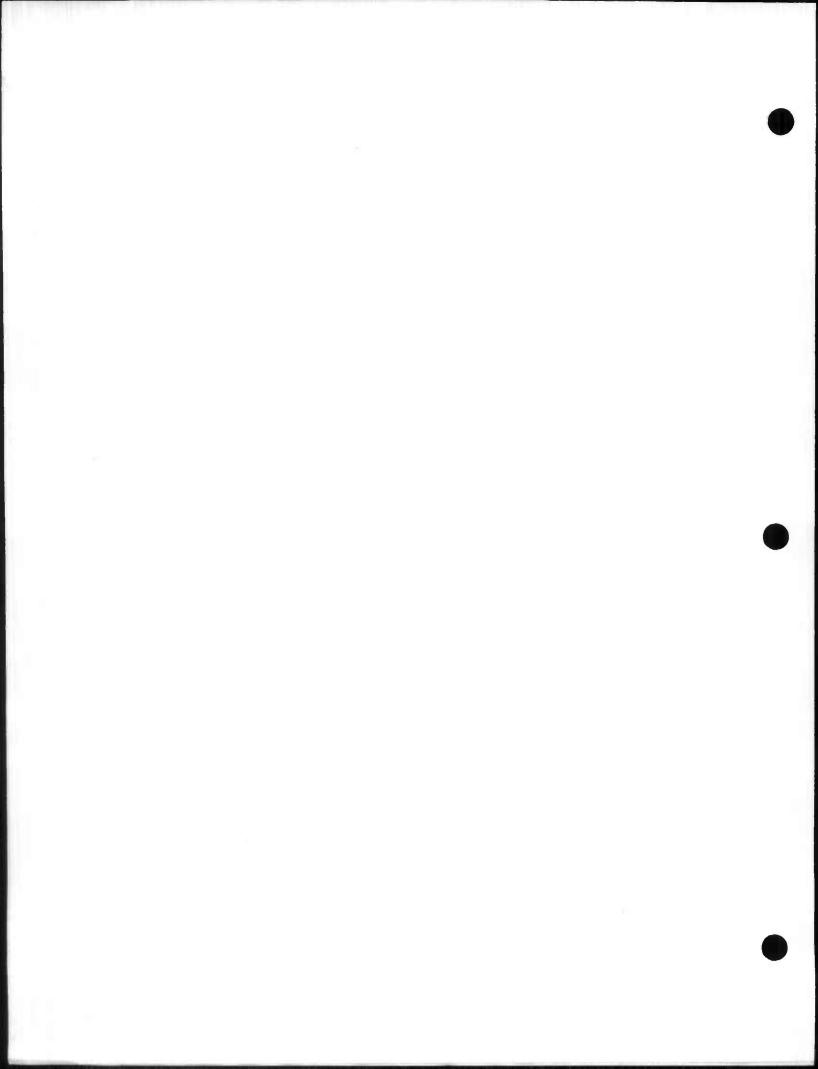
PRENGER,

NAME



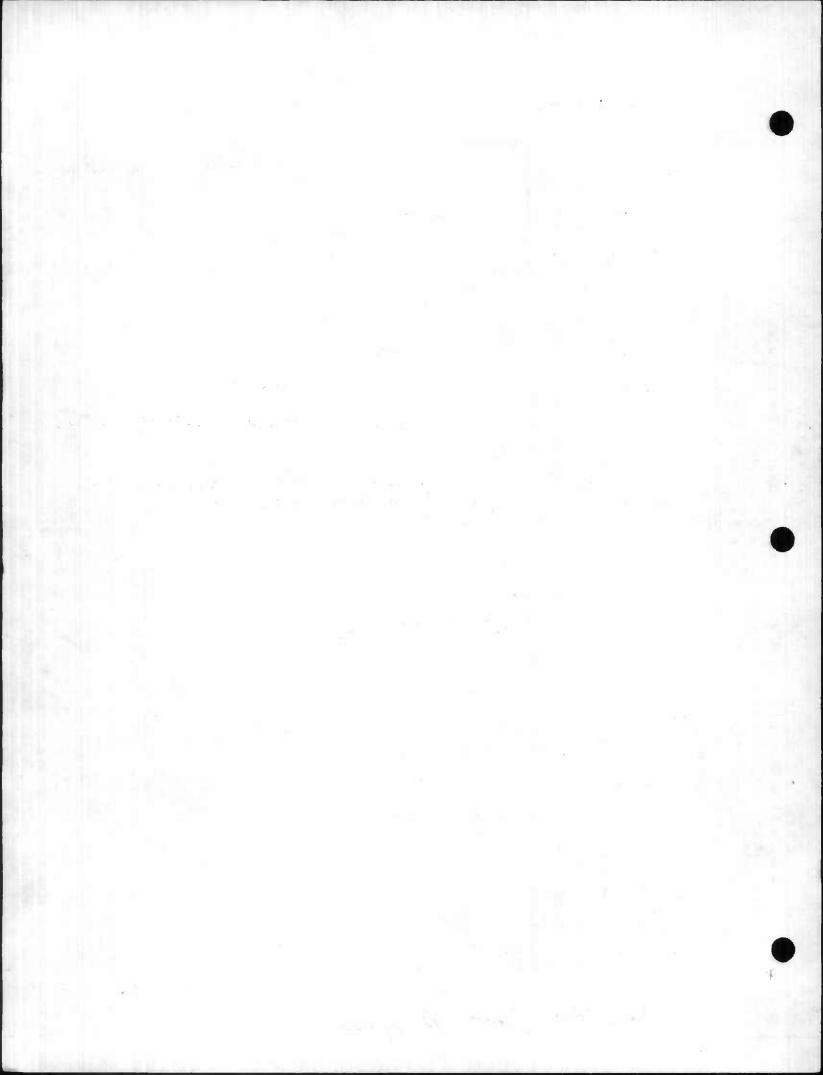
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				tificate c		1 - 5 - 45	Reg. No.		2 7	e of Death
	1, Decedent's Name (First, Middle, Last)					2. Date of D Month	Day	' वं		
Physician	Thomas M. R.	matodas				01	25	9		8:30 P
flandical -	4a Facility Name (If not institution, give	street and number)			4b. City, Town,	er Location of Dea	th 40.	County of		
Examiner	7888 Dusim R				Solisbu	ures_		Wid	omici	2
	5 Social Security Number 6. Set		last hidhdayl	Il Under 1 Ye	our If Under 24	19. Jain of B	irth	9	Birthplace (S.	tete or Foreig
Faneral		M 20F	Yrs.	Months De	ays Hours N	in. (Month, A	3/3		Ohio	
Director	211-39-010-4	(0)				1110	2/2			
	Usual Residence of Decedent 10a, State 10b, County	10e CR	y, Town or Lo	cation					10d. Ins	de City Limi
. FE			isbury				•		. 10	Yes 201
to the	Maryland Wicomico	Sai	isbury							
# E	10e, Street and Number			10f. Zip Co	de		10g. Ci	tizen of Wh	at Country?	1
25 0	7888 Dublin Road			21801			U.S	.A		4 Mar 1 Nov. 1014
85-E		12 Was Decedent Ever in U	J.S. 13		of Hispanic Origin Cuban, Mexican, P	7 (Specify Yes or	No		American Indi	an,
1 E E	11. Martini Status	12. Was Decedent Ever in U Armed Forces?	22	If Yes, specify	Cuban, Mexican, P	uerio Filozo, etc.)		BIACK,	White, etc.	
88 E	1 Never Married 212 Married	1 67 Yes 2 No If Yes, Give Year or Dates: 195	_	1 Yes 2	No Specify:		. }	Specify:	White	2
1 1	3 □ Widowed 4 □ Divorced)				1465 8	and of Busi	ness/industry	
49 6	15. Decedent's Edi (Specify only highest grad	is completed)	16a, Dece	Ments Deval O	ccupation tone during most of etirad)	working	100.1	VEIO OI MAN		•
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	17. Father's Name (First, Middle, Last)					Name (First, Mide)	
B son	Martin Clifford	Roe			Mary	Helen C	rooks	TOD		
To See			105 11:11	ing Address /0	Itreat and Number	Rural Route Nu	nber, City	or Town. S	Tate, 24 Cose)
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:55 PM John William Roche January 21, 1999 /Medical 4b, City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Franklin Square HOSP ta cente more If Under 24 Hrs 6 Sev If Under 1 Year 8. Date of Birth 9. Birthplace (Stete or Foreign April 30, 1916 Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Deys 1₽M 2□ F Months Hours 82 Director 215-03-2686 Usual Residence of Decedent 10a State 10b County 10c City Town or Location 10d. fnside City Limits permit. Pagas 1 and 2 should be filed within 72 hours after death with the Menylen Desartment of Health and Mentel Hygiene. Intercentant: if item 27 is marked other than "natural", or items 23a or 28a-1 show my injury or other traumatic event, its Magas Escriber man be notified as Maryland Baltimore Rosedale 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 Ridge Road 21237 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black, White, etc. 1 Tyes 2 No If Yes, Give 1 ☐ Never Married 2 🕅 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Year or Date 42-1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Patrick Roche Margaret Kneucker 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, Stete, Zip Code) 2901 Edison Avenue, Baltimore, Maryland 21213 Deloris Roche/wife 20b. Plece of Disposition (Name of cemetery, crematory or other ptece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licensee Loseph B 22. Name and Address of Facility
State Anatomy Board, 655 W. Baltimore Street Wan Sant Baltimore, Maryland 21201 23s. Part Lenter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate fntarval Between Onset and Death Physician /Medica Immediate Cause (Final disease or condition resulting in death) . Hypotensive E 20.25 Hours Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Infarction Myocardia 68760 Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 1 □ Y00 2 No 3 Probably 4 Unknown malnutrition, Cardio myopathy, 24b. Were autopsy findings evailable prior to 24a. Wes en autopsy performed? Type I Diabetes Mellitus, Coronary completion of cause of deeth? 1 Yes ZONo Artery Disease 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding 5 Pending investigation To the Hospital or Attandit within 24 hours after death. To the Funeral Director: A 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 5000 M.D January 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) malika Wasseem mp good Franklin Square Drive Baltimore mD, 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State JAN 27 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \ Certificate of Death 2. Dete of Death 3. Time of Death ecedent's Name (First, Middla, Last) January 20, 1999 Kichardson **Physician** nae 9 /Medical City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, giva straat and number) Examiner topkins Hospital Johns Altimore It Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** 9886 Days 1 M 2 F Months Hours Maryland Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f shor treumatic event, the Modical Experimentment be notified at 1 ☐ Yes 2 No Director 10e. Streef end Number 10f. Zip Code 10g. Citizen of What Country? 8912 Ro 21234 items 23s e Funeral filed within 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DNo if Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Bleck, Whife, etc 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Giva kind of work done during most of working
lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada complated) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) phone permit. Pagas 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 Is marked other eny Injury or other treumatic event page. 18. Mother's Name (First, Middla, Maiden Surname) 17. Father's Name (First, Middla, Last) Be 10 19b. Mailing Address (Streat and Number or Rurel Route Number, City or Town, Stata, Zip Code) 20b. Ptace of Disposition (Nama of cematary, cramatory or other place) 21734 20c. Location 20a. Method of Disposition - City or Town, State 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical & RESPIRATORY FAILURE DUE TO WITHDRAWL OF CARE 36 HOURS Examiner Physician/Medical Examiner 14 DAYS B. RUPTURED INTRACRANIAL AMEURYSM attanding physician and for usa as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events Due to (or as a consequence of) 14 DAYS MULTIPLE CEREBRAL INFARCTS resulfing in death) Lasf ed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 (Unknown been signed by þ 99 24b. Were autopsy findings avaitable prior to completion of cause of death? cartificeta hes been si irector, cada 2 should 24a. Was an autopsy Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital spital or Attending Physician: Thours eftar death.

nerel Director: Aftar this cartificet filled in by the funaral director, p Physician: 25. Was cese referred to medical Be 26. Place of Death (Chack only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatienf 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Yaar) 28d. Describe how injury occurred Injury at Work? 1 Natural 2 ☐ Accident 5 Pending Investigation 1 Yes 2 No 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral [
complataly filled Hospital edical 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier To the 29d. Date signed (Month, Day, Year)

JANUARY 20, 1999 29c. License number 29b. Signeture end fitle of certifier RES 3000 08772

30, Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

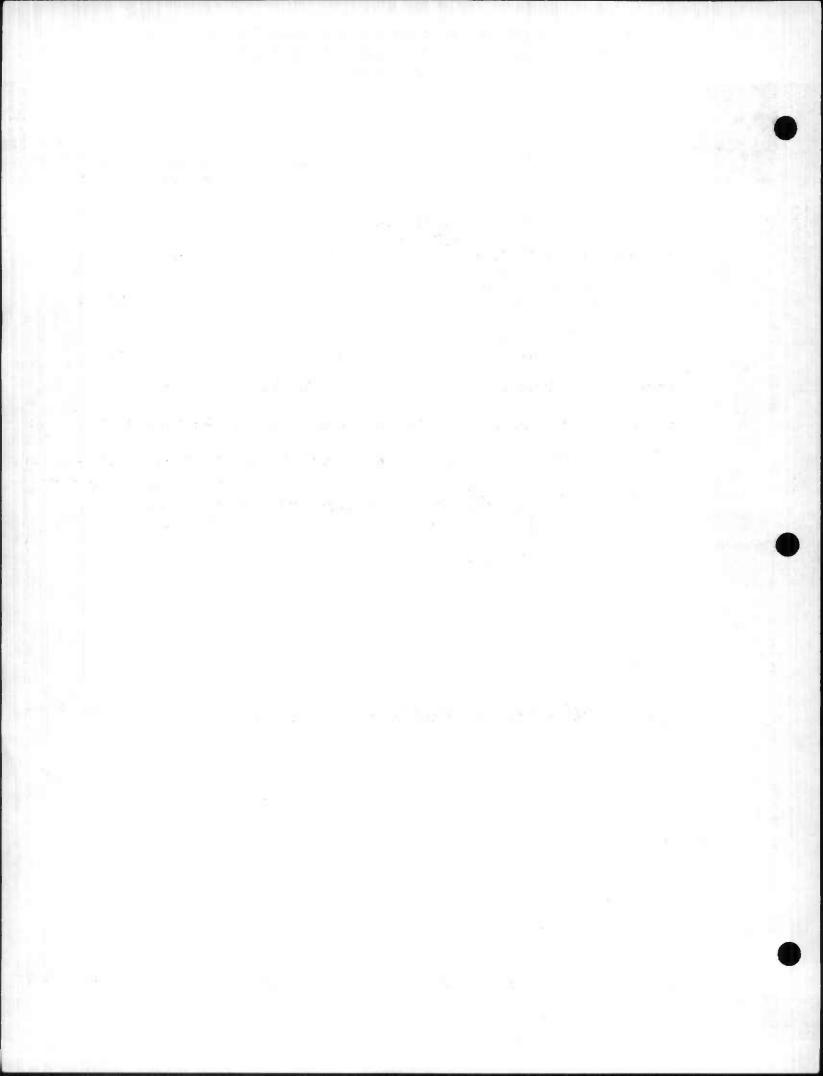
ABUTANTER M. YAHIA, MD 600 NORTH WOLFE STREET

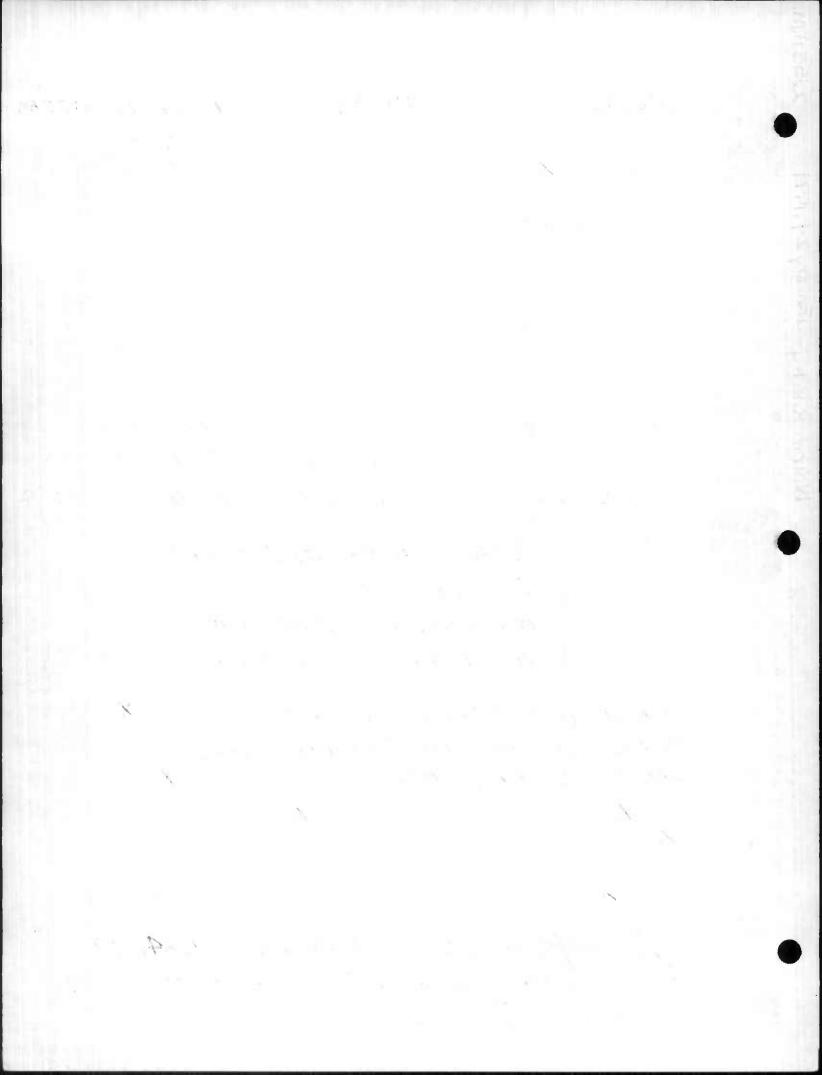
3. Registrer's Signature

State Registrar 31. Date fited (Month,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

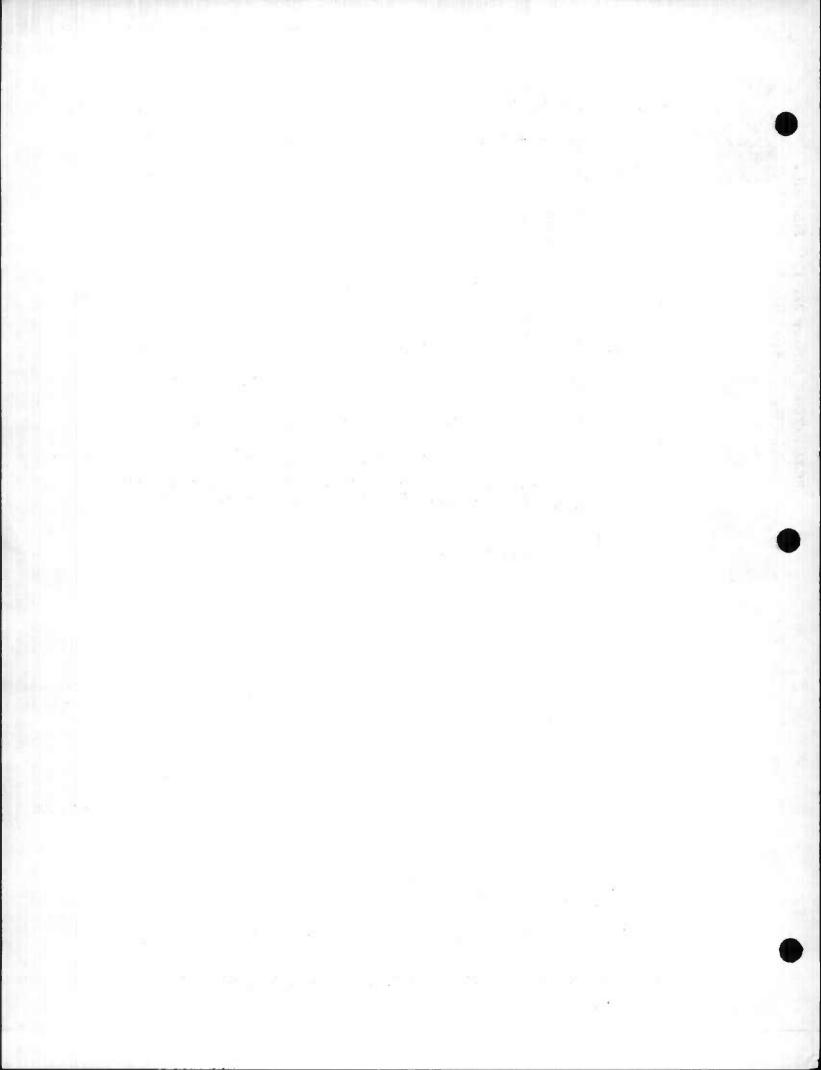
						Cen	tificate d	of Death		Reg. No.		1.7
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/Medic									01	24	99	10.50 PM
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death cerr death cerr e ettendin od for use	Slan											
P.O. Box that the death cert ed by the ettendin deteched for use	by Physician/N	Part II. Other signi	ficant conditions co	ontributing to death b	out not rasi	ulting in the und	derlying ceuse	given in Part t.		tobacco use co		the cause of death?
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0 = = a	ation: To	27. Manner of Dea 1 ☑ Natural 2 ☐ Accident		28a. Date of Inju (Month, Da		28b. Time of Injury		niury et Work?	Home 5 ☐ Res 28d. Describe	how Injury occur		7)
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homlcide	6 Could not be determined	28e. Place of In building, et	jury - At ho c. (Specify	ome, farm, stree	et, factory, off	ice		(Straet and Num wn, State)	bar or Rura	I Routa Number,
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5		30. Name and add	ress of person who d				rint)	% ma	exiland	Grene	ral	199 Hospital
Stat Registra		31. Date filed (Mor	nth, Day, Year)	32. Registr	rar's Signa	ture &.	Loc	uls				





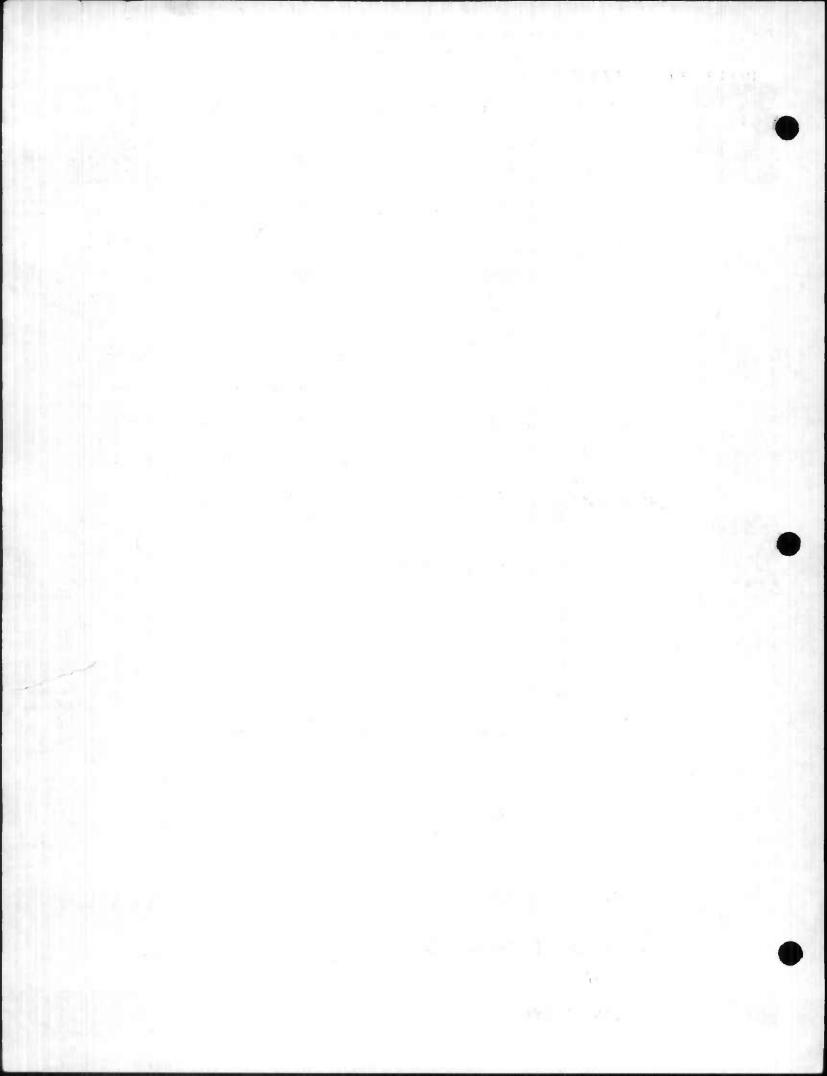
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tic e	To B	Arthur Hays					Ida	S. Lipt	rap		
5		19e. Informant's Name/Reletionship (Type, Print)	198	. Mailing Addres	s (Street	end Number or Re	ural Route Numbe	r, City or Town,	State, Zip Code)
any injury or other tra		Carol Pritche	tt /daug				pski Rd	Esse	ex, MD	21221	
5		20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □	Removel from State	20b. Plece o	f Disposition (Nerry, cremetory or	ome of other ple	се)	Jan 29	20c. Location -	City or Town, S	tete
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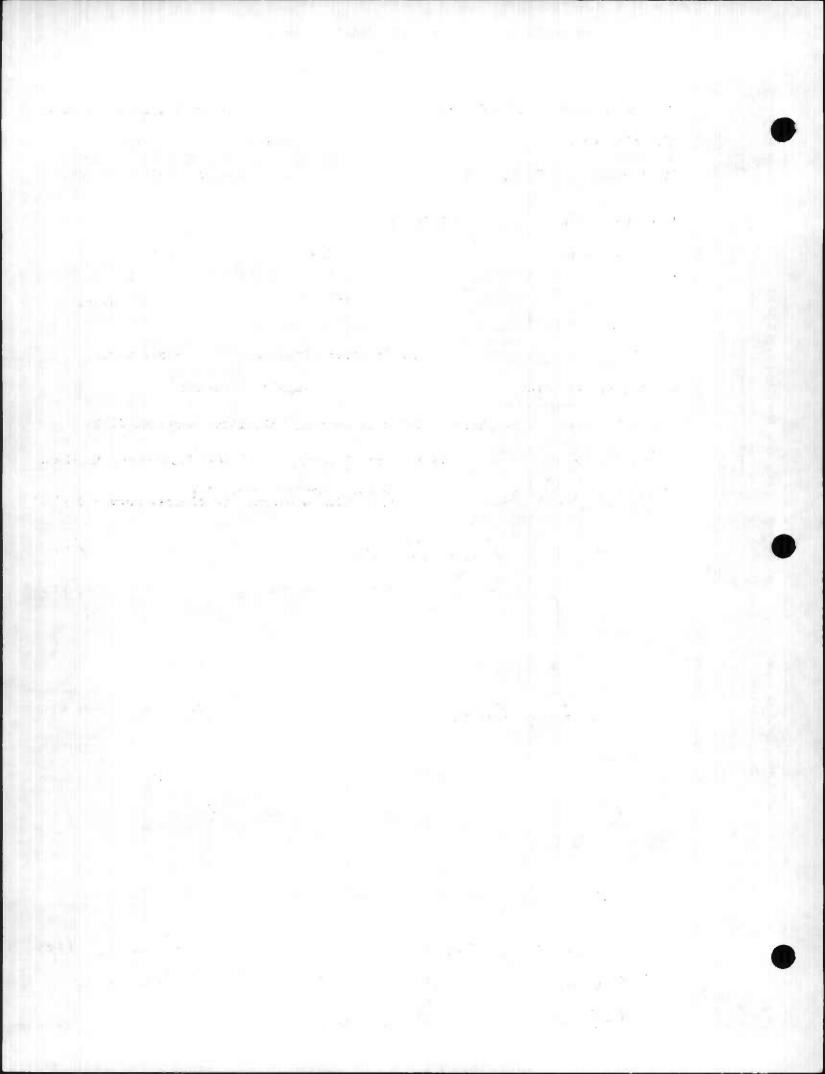
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Bon Secour Hospital Bon Secour Hospital Bon Secour Hospital S. Social Security Number 219-22-4923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore 10c. City, Town or Location Baltimore 10d. City Town or Location 11d. Marital Status 11d. Marital Marital Status 11d. Marital Marita	Birthplace (State or Foreign Country) Maryland
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219-22-4923 XOM 2 F 69 Yrs. Months Days Hours Min. April 10 1929	Maryland
10a. State 10b. County 10c. City, Town or Location 10d. Zip Code 10g. Citizen of What of Dept of Hu 10d. Zip Code	10d. Inside City Limits
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Newman Reavis 18. Mother's Name (First, Middle, Meiden Sumeme) 19a. Informant's Name/Relationship (Type, Print) daughter Sherean Reavis 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility 16b. Kind of Busines (Give kind of work done during most of working life. DO NOT use retired) State of MD/ City of Philadelphia 18. Mother's Name (First, Middle, Meiden Sumeme) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete 18 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licansee 22. Name and Address of Facility 2501 Gwynns Falls Pkwy	
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1 M Burial 2 Cremation 3 Removal from State Arbutus Memorial Park Jan 16 Baltimore	
	County MD
Baltimore, MD 21216	3,000
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death) a. Concer of Orofkarynx with Metastass to Lungs where to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
We de la constant de	
d	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	
1 Yes 2 No 3	Probably 4 Unknow
performed?	b. Were eutopsy findings available prior to completion of cause of deeth?
N	1 ☐ Yes 2 ☐ No
© 25 Was case referred to medical	10100 2010
1 I I Tes ZJetno 1 I Innatient 2 V FB/Outnatient 3 DOA Albertage Home 5 Residence 6 Other /St	pecify)
	posity
27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury at Work? Injury 3 Suicide 3 Suicide 6 Could not be 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury at Work? Injury M 1 Yes 2 No	
27. Manner of Death 27. Manner of Death 28d. Describe how injury occurred	Rural Roufe Number,
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifler (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Placa of Injury - At home, farm, street, factory, office 28f. Location (Sfreet and Number or City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office 28e. Placa of Injury - At home, farm, street, factory, office 28f. Location (Sfreet and Number or City or Town, Stete) 28f. Location (Sfreet and Number or City or Town, Stete) 29a. Certifler (Check only one) 29d. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end place, and determined 29d. Date signed (Mo	
The state of the property of t	es steled. due to the ceusa(s)
30. Name and address of barrach who completed cause of deeth (Item 23e) (Type, Print) LIAD AT AU JUN Eutew Street Baltanore MD 2/2	onth, Dey, Year)
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)	onth, Dey, Year)
LIADAT ALI JUN Eutew Street Ballimore MD 2/2	onth, Dey, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	onth, Dey, Year)

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Please Type or Print In Black Indelible ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 9

		Certificate of	of Death	Reg	. No.	
	Decedent's Nama (First, Middla, Last)			2. Data of Deeth Month	Dey Ye	3. Tima of Death
Physician /Medical	Charles Melchoir Reinhardt,	III		January :		
Examiner	4e Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	cation of Death	4c. County of E	eath
	759 Yale Avenue		Baltimore		N/A	
Funeral Director	5. Social Security Number 213-12-2018 6. Sax 1 M 2 F 7. Age (In 77)	yrs. last birthday) Yrs. If Undar 1 Yr Months Da	ys Hours Min.	8. Data of Birth (Month, Dey, Y Nov. 23,	9. 1921 M	Birthplaca (State or Foraign Country) aryland
anyland ahow		c. City, Town or Location				10d. Inside City Limits
the Man 28e-f sh nodiled	Maryland N/A Ba	altimore 10f. Zip Coo	40	100	g. Citizan of Wha	1 Ži Yas 2 □ No
ifer death with the Ma r fleme 23s or 28s-fs for man brodilise Funeral Director	759 Yale Avenue		229	101	USA	
72 hours after death with the Maryland natural; or Items 23s or 28s-f ahow of a language of the control of the	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ② No If Yas, Give Yaar or Datas:	in U,S. 13. Was Decedant If Yas, specify (of Hispanic Origin? (Spe Cuban, Mexican, Puarto f No Specify:	city Yas or No- Rican, atc.)		Amaricen Indian, Whita, atc. White
led within 72 hours lygiane. The the matural, it, the wester Ex.	15. Decedent's Education (Spacify only highast grada completed)	16a. Decedant's Usual Oc (Giva kind of work do lifa. DO NOT usa ra	ona during most of working	ng 16	6b. Kind of Busine	ass/Industry
Hygiane. Other than ent, tre We	Elementary/Secondary (0-12) Collaga (1-4or 5+) 12 2	Architectur			State Go	vt.
\$ 5 5 00	17. Fathar's Nama (First, Middla, Last) Charles M. Reinhardt		Angela Ka		aldan Sumama)	
d 2 should th end Mer 7 is marke traumatic	19e. Informant's Neme/Reletionship (Type, Print)	19b. Mailing Addrass (St.	reet and Number or Rura	Routa Number, (City or Town, Ste	te, Zip Code)
C T N L	Brenda C. Parks / Daughter	759 Yale Av		more, Ma	ryland 2	1229
Pages 1 enc nant of Healt int: If item 27 ury or other	1 ☑ Buriel 2 ☐ Crametion 3 ☐ Removel from Stete	Ob. Placa of Disposition (Nama o comatary, cramatory or other Loudon Park Cen	plece)		Oc. Location - City altimore	or Town, Stata , Maryland
permit. Pages 1 er Department of Hea Important: If item: any injury or other	21. Aggatum of Funeral Servica (rounsea		ddress of Fecility Funeral Homo kens Avenue		ore. Mar	vland 21229
Dhusisian	23a. Part1. Entar tha disaasa, or complications that cousad tha shock, or haart failura. List only ona causa on each lina.					Approximata Interval Between Onset and Deeth
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<u> </u>	rasulting in daath)	to (or as e consequence of):	Deserve			CVCI
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ettending pl for use es t	d					
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The law requires that the deeth ce cate has been signed by the ettendi, page 2 should be detached for us.				24e. Was an performa	autopsy 2 ad?	4b. Wara autopsy findings evailable prior to complation of causa of death?
The law ate has page 2				1 □ Yas	2 2 No	1 ☐ Yes 2 ☐ No
certificate rector, pag	25. Was case referred to medicel axaminar?		26. Plece of Death	(Check only ona)	
000	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatiant	2 ER/Outpatient 3 DOA	Other: 4 Nursing Hor		nce 8 Other (Specify)
Attending Phy ir death. ector: After thi by the funeral ification: T	27. Menner of Daeth 1 Netural 5 Panding 2 Accident Invastigation		Injury at Work? 1 □ Yes 2 □ No	28d. Ďaschbe hov	w injury occurred	
or Attending efter death. Director: After d in by the fune ertification	3 ☐ Suicida 6 ☐ Could not be detarmined building, atc. (S	At homa, farm, straat, factory, of pecify)	fice	28f. Location (Stre City or Town,		or Rural Routa Number,
Hospital 24 hours Funeral Italy filled	29a. Certifiar (Check only Certifying Physician: To the best of my Check only Check only Certifying Physician: To the best of my Check only Certifying Physician: To the best of my Cer					
within 2 To the comple	29b. Signature and tiply of certifier	29c. Lle	cense number	29	d. Deta signed (A	fonth, Day, Year)
0	> Celh Clilatufus?	NO 0	24356	C	Fanna	25, 1999
	30. Name and eddress of person who completely use of deeth Wm CW47ENFICA	(Item 23a) (Type, Print) FAgne Cince	Centy 90	Balt.	toplo	1225
State Registrar	JAN 2 7 1999	Signature Ann. 4	,			,



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) EDWARD ARTHUR RIDER 1999 JANUARY 24 1513 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) ST. AGNES HOSPITAL BALTIMORE N/A If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Deys Hours 10 M 20 F Yrs 220-01-6616 BALTIMORE, MD JULY 1,1922 Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N☐ Yes 2☐ No BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21230 U.S.A. 1929 HARMAN AVENUE 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MANUFACTURING 5th Grade ASSEMBLER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) MARGARET C. McLAIN ARTHUR H. RIDER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Name/Reletionship (Type, Print) 1929 HARMAN AVENUE - BALTIMORE, MARYLAND 21230 EILEEN E. RIDER (WIFE) 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Deceion 5 ☐ Other (Specify) 1/28/99 BALTIMORE, MARYLAND LOUDON PARK CEMETERY 22. Name end Address of Fecility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 23e. Pert1. En er the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) · acute myocard Due to (or as consequence of): coronary ortery Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contributa to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown rillation, Chronic 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en autopsy performed? pulmanary discose, Charletes 25. Was case referred to medical exeminer? 28. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 KNo 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28c. Injury et Work? Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one)

0 Registrar

State

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any injury or other traumatic event, that DDGs.

Physician

/Medical

Examiner

Examiner

Physician/Medical

pA

Be

altimore, Maryland 21215-0020

Directo

Funeral

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scannice 31. Dete filed (Month, Dey, Yeer) JAN 27 1999

29b. Signature and title of certifier

20 32. Registrer's Signeture

3. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Agnes Hospital Baltimas

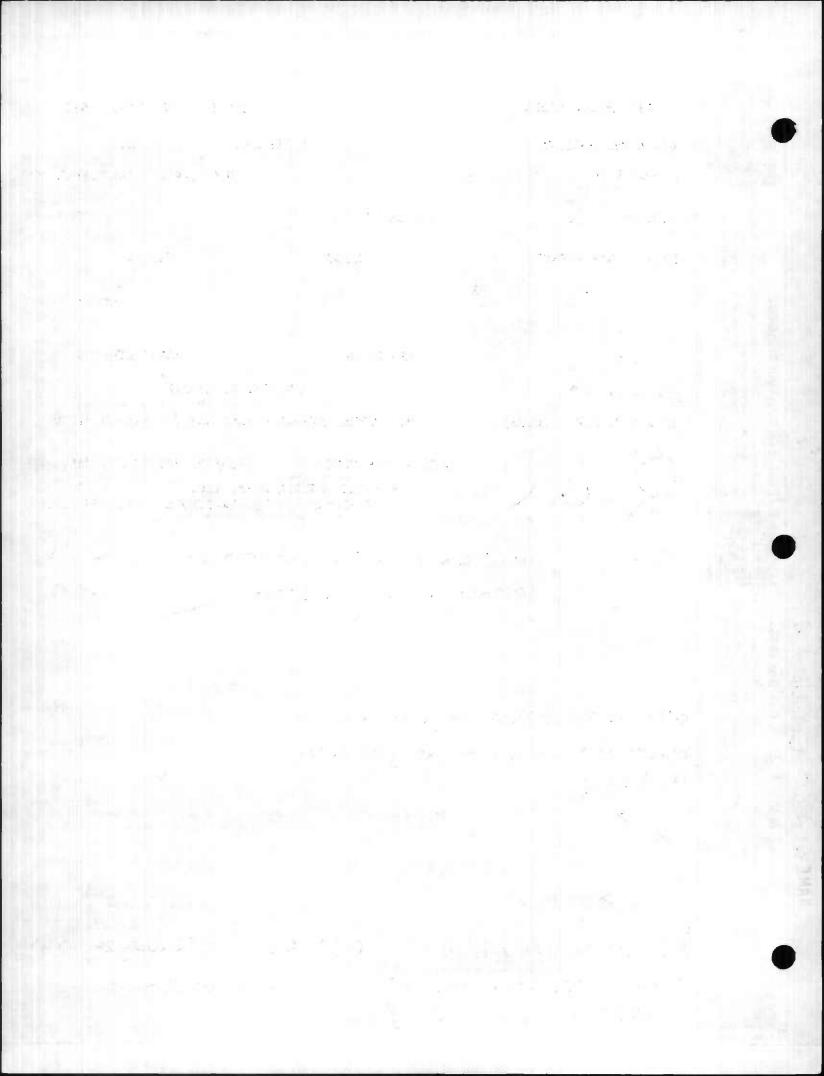
29c. License number

33061

29d. Date signed (Month, Dey, Year) January 24, 1999

DHMH 16 Ray 6/95

To the 2



FRANKL

/Medical Examiner

P.O.

Division of Vital Records.

or Attend after deatl Director:

Hospital 24 hours a

2 To the F

Physician

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Lower Lobe week Due to (or es e consequença of) Due to (or es a consequence of) Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest

1. Decedent's Name (First, Middle, Last)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Multi-INFARCT DEMENTIA LymphomA.

ARGE CELL MAIGNANT

24e. Wes en eutopsy performed?

24b. Were eutopsy findings aveileble prior to completion of cause of death? 1 ☐ Yes 2 No

Approximete Intervel Between Onset end Deeth

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

4:00 am

Perpheral ARTERIAL
25. Westase referred to medical exemine?
Hospital 1 Yes 2 No

5 Pending

Investigetion

6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 28b. Time of

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work?

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death

BINSON

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Piece of Death (Check only one)

2. Dete of Death

January

28d. Describe how injury occurred

29a. Certifier (Check only one)

27. Menner of Deeth

Neturel 2 Accident

3 Suicide

4 D Homiclde

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and pieca, end due to the ceuse(s) end menner stated.

29b. Signature and title of cartifier

29c. License number

1 Yes

2 🗆 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

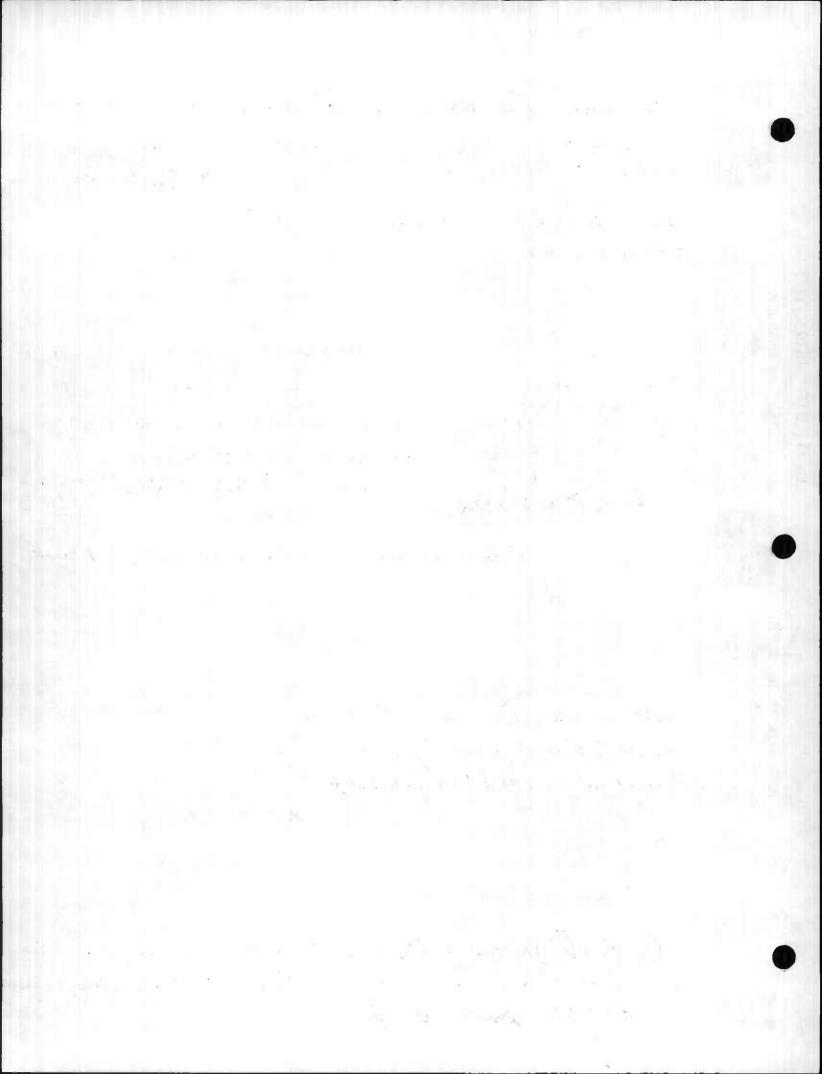
ATTENDING MYSICIAN of person who completed cause of deeth (Item 23e) (Type, Print)

NUARY & 6, MAIDEN ChOICE LA,

Registrar

31. Dete filed (Month, Day, Year) JAN 27

N.M. MACHIRAN 720-C 32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 10 25 AM John Thomas Robinson, Sr. January /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Maryland retimore City Greneral N/A 5. Sociel Security Numbe 6. Sex 1 M 2 □ F If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Dec 21, Birthplece (State or Foreign Country) Funeral Deys 213-22-9472 76 Yrs MD Director Usual Residence of Decedent the Meryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Merylan Depertment of Health and Mental Hygiene. Important: If term 27 is arrected other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, its feeting beaution matter the motivad as Yes 2 No Director N/A Baltimore 10e Street and Number 10f. Zin Code 10g. Citizen of Whet Country? 2403 St. Stephens Court Apt.3A 21216 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 → Yes 2 □ No If Yes, Give 13. Was Decedent of Hispenic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No py f Yes, Give Yeer or Dates:45 – 46 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Security Elementery/Secondery (0-12) College (1-4or 5+) Clerk Administration 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Daniel Richard Robinson Ollie Jolley 10 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Juanita E. Robinson (Wife) 2403 St. Stephens Court Apt. 3A Baltimore, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Slete Dete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State Jan 28 4 ☐ Donetion 5 ☐ Other (Specify) Vienna, MD Robinson Family 1999 21. Signature of Funeral Service Licensee Calvin L Williams Funeral Service 270 Fredhilton Pass Baltimore, MD 23a. Pert1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medicai Immediete Cause (Finel diseese or condition resulting In deeth) Examiner Examiner sicien and burial-trensit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lesi physicien as the burial Box 68760, Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the detached 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yas 2 ☐ No 3 Probably 4 2 Unknown þ 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy peen hes page 2 1 PYes 2□ No 2 No 25. Wes cese referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 □ ER/Outpetient 3 □ DOA After this funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28c. Injury et 28d. Describe how Injury occurred To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: After 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident the 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streel, fectory, office building, etc. (Specify) pletely filled in by 4 Homloide edical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Dey, Year) 30. Nergre end eddress of person who completed couse of deeth (Item 23e) (Type, Print)

30. Nergre end eddress of person who completed couse of deeth (Item 23e) (Type, Print)

MARYLAND GENERAL HOSP.

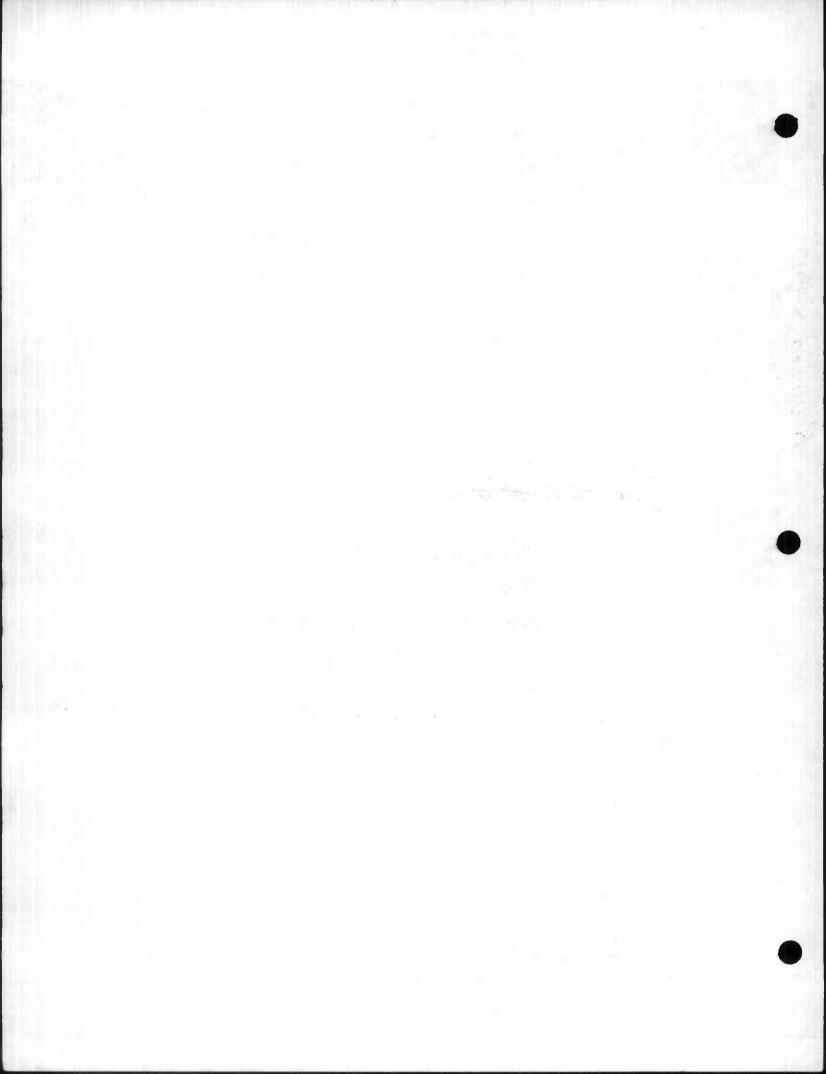
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Registrar

31. Dete filed (Month, Dey, Year)

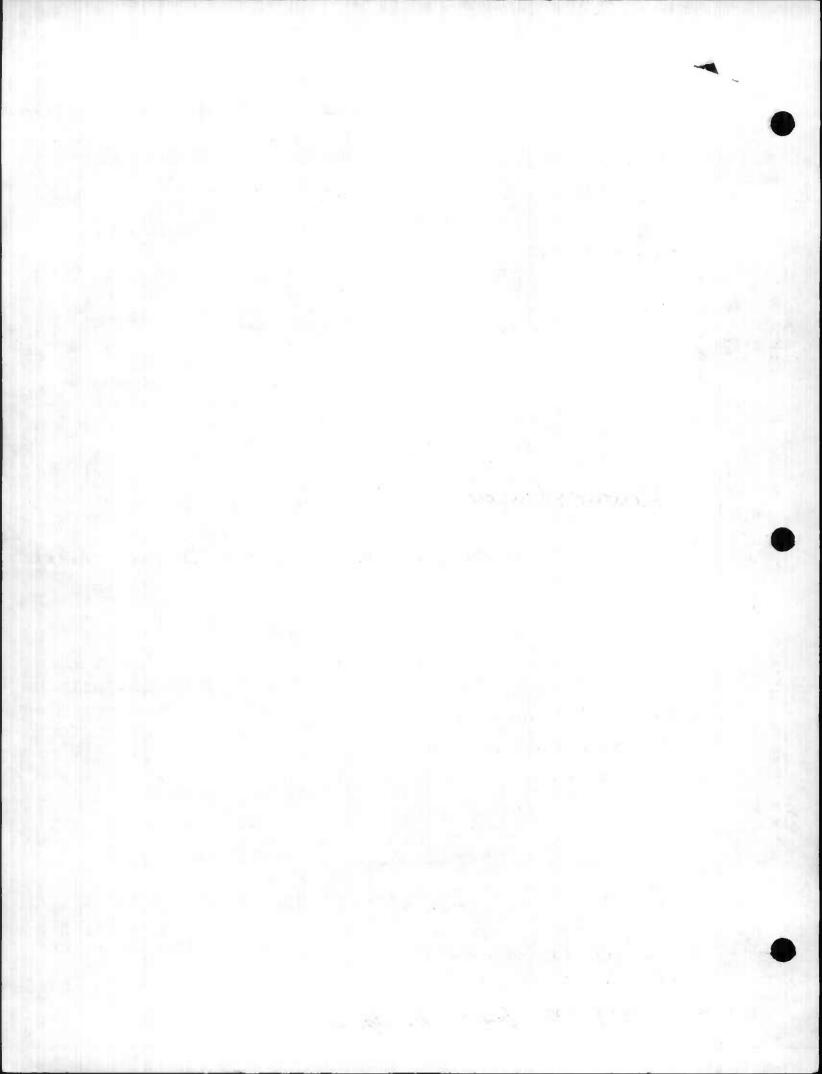
32. Régistrer's Signeture

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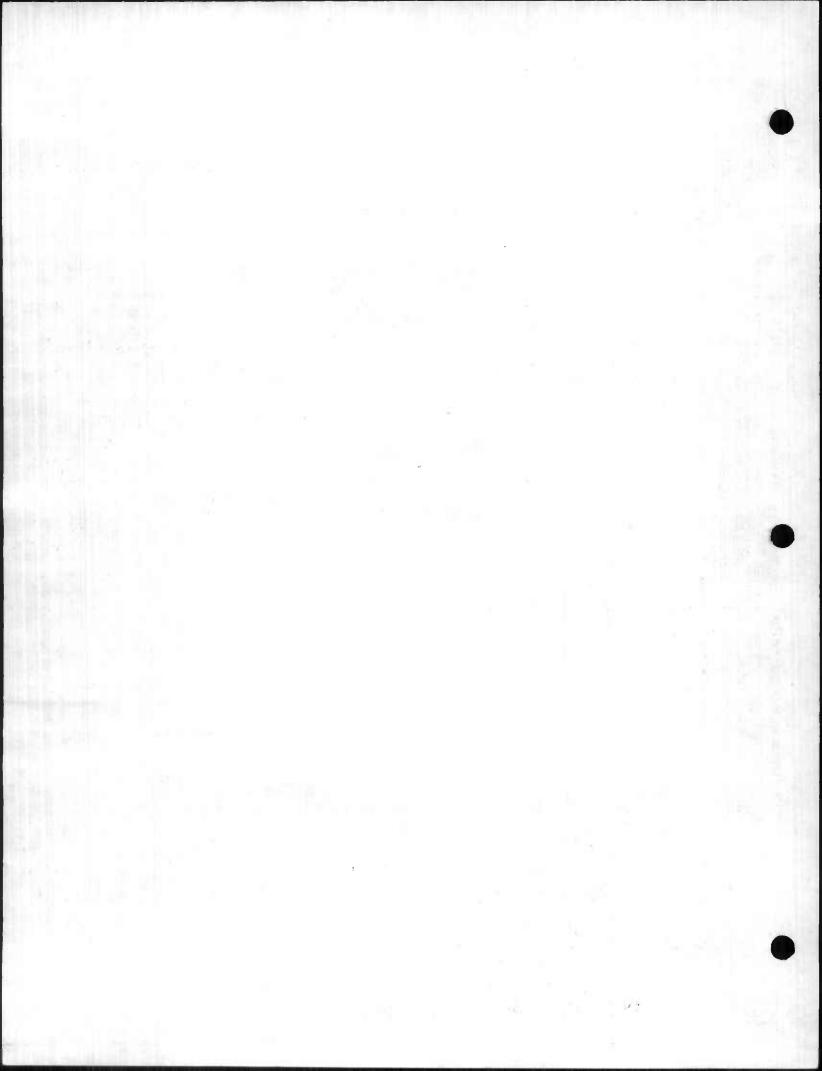
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	-	_				Cert	ificate (of Deat	h		Reg. No.			
		Decedent's Name (First, Middle, Last)								2. Date of D	eath	Year	3. Time of Death	
	Physician /Medical	Letta Silitin						JANUAR	Day 20 /	1999	7:51 Pm			
	Examiner	4a Fecility Neme (If not Institution, give street end number)						4b. City, Town, or Location of Deeth 4c.				of Deeth		
		Washington Adventist Hospital Takoma								_	omery	County		
	Funeral Director	5. Sociel Security Numb	ex 7. ☑ M 2□ F					er 24 Hrs. Min.	8. Dete of Bi (Month, D May 25	rth ey, <i>Year)</i> 1920	Coun	lece (Stete or Foreign try) ngs,Kentuck		
	2	Usuel Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits										Od. Inside City Limits		
Baltimore, Maryland 21215-0020	e Maryle									1∑ Yes 2 No				
	th with the Ma 23e or 28e-fi an be notified	10a. Street and Number 1836 Metzerott Road					10f. Zlp Code 20783				10g. Citizen of What Country? United States of America			
	72 hours after deeth with the Maryland natural; or forms 23s or 28s-f show deal Examerer must be notified at the funeral Director	3X Widowed 4 □	_	12. Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2□ No 1942— If Yes, Give Year or Detes: 1949			Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) □ Yes 2 No Specify:				14. Race - Americen Indian, Bleck, White, atc. Specify: Black			
	led within 72 hours lygiene. Per then "neturel", It, I'm Med cel Ext	15.	Decedent's Ed		cation 16a, Deced			cupation	ost of worl	kina	16b. Kind of Business/Industry			
	within ene.	Elementary/Secondar	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)								
	other th	5	5			Laborer					C&O Railroad			
	Ball H	17. Father's Name (First, Middle, Last)								e (First, Middle, Maiden Surname)				
	should bant marked umarked						Fanni	nie Not Available Rural Routa Number, City or Town, Stata, Zip Code)						
	d2 th ar Tie treu	Harriet L.									Marylar			
	ges 1 and it of Health if item 27 or other t	20a. Method of Disposit		Daugnee							20c. Location -	City or To	wn. Stata	
	Page ent c nt: If	4 □ Donation 5 🖸	1 Burial 2 Cremation 3 Removel from State 4 Donation 5 Mother (Specify) Entombment Blue Ridge Memorial Gard 20, 1999 West Virginia											
Bal	Departm Importar any inju	21. Signetate of Funerel Service Licensee 22. Name and Address of Fecility Richie and Johnson Funeral Chi 748 South Fayette Street, Bec									1 Chapel	. We	st Virginia	
	/Medical Examiner	Immediate Cause (Fina disease or condition resulting in deeth)		а. <i>ДЛ</i>	Due to (or as a	e conseque	ence of):	4001	DVA	RWIAR	Diseas	2	Years	
x 68760,	settlicate be executed ding physician and se as the bunal-transit	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disaase or injury that initieled events resulting in death) Lest Due to (or as a consequence of): Due to (or es a consequence of):												
Box	death cert e attendin od for use	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause												
Il Records, P.O	that the red by the detached	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VAS CULAR DEMISSITIA									17			
	requires	Cenesa	Ceneral Infanction Itypenson						s an autopsy ormed?	avi	ere autopsy findings allable prior to mpletion of ceuse death?			
	sician: The lew sician: The lew sicentificate has birector, page 2 sicentificate has birector, page 2 sicentificate birectors.	Huren	1621	501100					15	Yes 212 No	1 ☐ Yes 2 ☐ No			
	entifical octor, p	25. Was case referred t						26. Pla	ice of Dea	th (Check only one)				
>	Physician: this certific rel director, TO Be			Hospital: 1 Inpe	atient 2 ER/C	Outpatient	3□ DOA	Othor:	-		idence 6 Oth	er (Specify	y)	
Division of	Attending Physical death. ector: After this by the funerel of the		Panding investigation	28a. Dete of Injury (Month, Day Year) N 28b. Tima of Injury Injury M 1 Yes 2 No					28d. Describe how injury occurred					
	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director. After completely filled in by the funeral Medical Certification:	3 Suicide 6	6 Could not be						28f. Location City or To	281. Location (Street and Number or Rurel Route Number, City or Town, Stete)				
		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, daeth occurred at the tima, deta and plece, and due to the ceuse(s) and mannar as stated. Check only one) Certifying Physician: To the best of my knowledge, daeth occurred at the tima, deta and plece, and due to the ceuse(s) and mannar as stated. Check only one)												
	on the omple	29b. Signeture end title of certilier 29e. License number						of .		29d. Dete signed (Month, Dey, Year)				
	->-0							,	JANUARY 21, 1999					
	2	30. Nama and addrass of	, DE	VORE,	40 420) (Type, Pr	rint) V-len	stury	Rel	Hya	t/sv://-	M.	0 20781	
	State Registrar	31. Dete filed (Month, D			strar's Signature	9.	loan	1						



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hysician	1. Decedent's Neme (First, Middle, La	st)	001	tificate of	1	2. Date of Dea		3. Time of	Death		
/Medical	Margare 4a Facility Name (If fot institution, giv	Bowd and number	50	hmidte	hen 4b. City, Town, or 1	Januar		99 12:00	OPM		
xaminer	6705 Windsor Mi					ce County					
neral ector	5. Sociel Security Number 212-05-0219 6. S	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country) March 25, 1911 Maryland					
	Usuel Residence of Decedent 10a. Stete 10b. County				10d. Inside Cit	ty 1 imite					
for to	Maryland Baltime	ore Bai	ltimore	County				1 ☐ Yes			
at he notified a	10e. Street and Number 6705 Windsor Mi		10f. Zip Code 21207		1	10g. Citizen of What Country? U.S.A.					
Examiner must by Funeral	11. Meritel Stetus 1 Never Married 2 Merried 3 Vidowed 4 Divorced	1 Never Married 2 Merried Armed Forces? 1 Yes 2 No			lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	or No- 14. Race - American Indian, Bleck, White, etc. Specify: White				
Completed	15. Decedent's Ec (Specify only highest gra Elementery/Secondery (0-12)	Ucation de completed) College (1-4or 5+)	(Give	ent's Usual Occup kind of work done NOT use retired erator	nation during most of wor d)	ion ring most of working		16b. Kind of Business/Industry Telephone			
Be Co	17. Fether's Neme (First, Middle, Last)			Clator	18. Mother's Name (First, Middle						
ToB	William E. Bond		Margare				et A. Rest				
	19e. Informent's Neme/Reletionship (The second secon			Route Number, City or Town, Stete, Zip Code)				
	Mary R. Leppert/				Mill Roa			ryland 212	.07		
	20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)						20c. Location - City or Town, Stete				
9008	21. Signature of Funderal Service Licer Ronald S	Wade Direct	or		ss of Facility atomy Boa e, Maryla			imore Stre	et		
	23e. Part1. Enter the diseese, or com- shock, or heart failure. List only	plicetions thet caused the decone cause on each line.						Approximete Interval Bety Onset end D	neew		
ian cal ner	Immediate Cause (Final disease or condition resulting in death)	a. Cone	35 to	x Hen	+ Fo	i'line		24	~5		
		Due to	(or es a conseq	uence of):	and	in vorsu	lu de	ien 54	115		
s the bunal-transit	Sequentially list conditions, if env. leeding to immediate	Due to	(or as a conseq	uence of):		/		10			
三四	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	4)		(0)	1000						
								10	905		
ician/M	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.				23b Did to	23b. Did tobacco usa contribute to the cause of death?				
be cetached for use at by Physician/M	or in other significant dorientoria o	Sauting at the ta	oning it the artistrying sease given it is it.				1 Yes 2 No 3 Probably 4 Unknown				
page 2 should be d				5.04		24a. Wes a perform	n autopsy med?	24b. Were eutopsy fi available prior to completion of co of death?	0		
EO						1 🗆 Y	es 2MNo	1 🗆 Yes 2 🗆	No		
director, page	25. Wes case referred to medical examiner?	o medical 26. Place of Deeth (Check only one)									
9	1 ☐ Yes 2 No 27. Mennesof Death		ER/Outpatien		4 Nursing Home 512 He		Residence 6 Other (Specify)				
tlon	1 Neturel 5 Pending investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of lnjury at Work? M 28c. Injury at Work? 1 Yes 2 No								
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State)									
completely filled in by the funeral Medical Certification:	29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.										
Medical Certification	29b. Signature and title of partition 29c. License number						29d. Date and (Month, Dey, Year)				
) (/ /	9	9 1/15/99								
			-1								
	30. Name and address of person who	sompleted cause of death (Ite		Print)	20 6	~. Ro	(hi p	al Bu	18		



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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** Januarry 11:31 pm GLORIA M. SCHWARTZ 21 1999 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimoire AGNES HEALTHCARE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) **Funeral** Months Deys 1□ M 2K) F Director 215-28-9497 BALTIMORE 10a Stete 10b. County 10c. City. Town or Location 10d foside City Limite 1 ☐ Yes 2 No Director 28a-f MARYLAND BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code b 238 5528 CHANNING ROAD 21229 U.S.A.

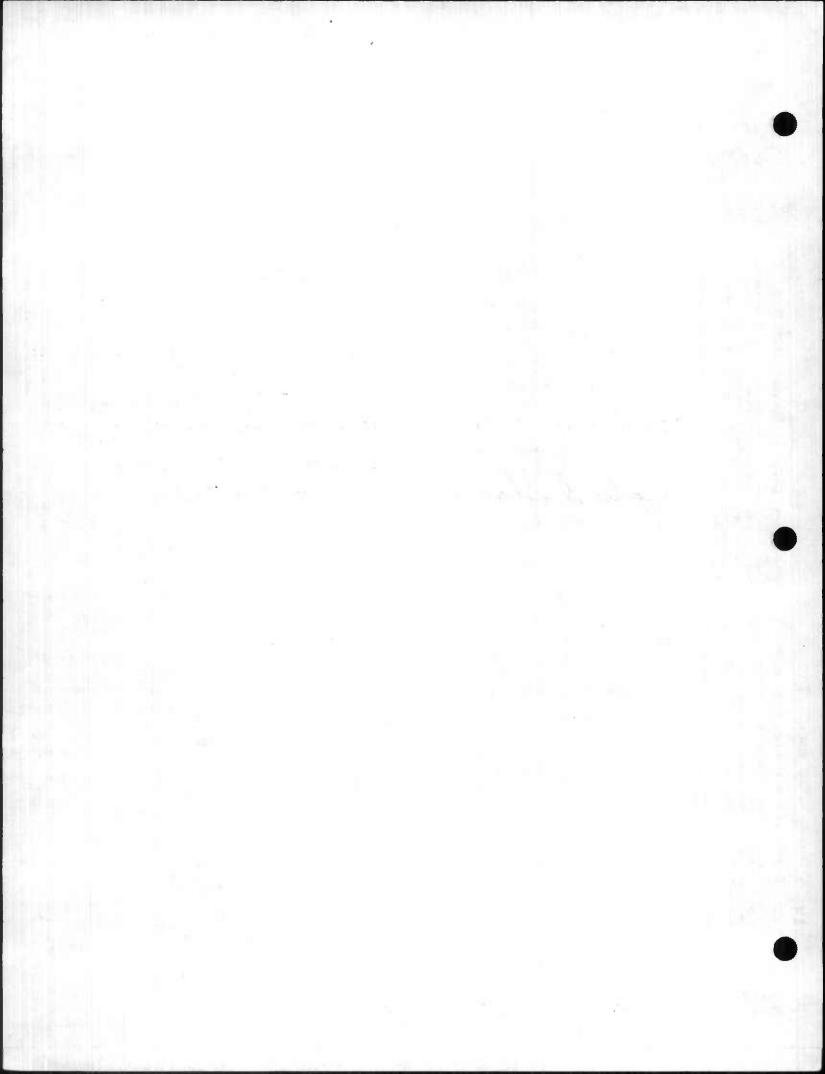
14. Race - American Indien,
Black, White, etc. Funeral 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried altimore, Maryland 21215-0020 ò 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) UNIFORM MANUFACTURER 12TH GRADE CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental WILLIAM KLEIN LILLIAN FARRELL 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if Item 27 is or other tra HENRY B. SCHWARTZ (HUSBAND) 5528 CHANNING ROAD - BALTIMORE, MARYLAND 21229
e of Disposition (Name of Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 1 M Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) LORRAINE PARK CEMETERY 1/25/99 BALTIMORE, MARYLAND 21. Signeture of Funeral Service Uf 22. Name end Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MARYLAND 21229 23a Park Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical fmmediate Cause (Final Hyperkalemia minutes diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examine Years Renal Failure physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Year o Collonary Box 68760. Arren Disewe Physician/Medical Due to (or es e consequence of) Years Hypertension for use signed by the a Pert If. Other afgniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 035trunctive pulmonny Diserse à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Pheumonic 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1☐ Yes 2⊠ No this funeral 27 Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? After 5 Pending investigation or Attending Division 1 X Natural after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) To the I within 2 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Day, Year) P11698 January 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) , mb 21229 Bul timorre ParikH Catan 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JAN 2 Registrar oak

DHMH 16 Rev 6/95

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SCHWARTZ



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death JANUARY 25, 1999 Calvin F. Sinclair 10:45 AM 4a Escility Nama (If not institution, give street end number) Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Center Towson Baltimore 7. Age (In yrs. last birthday) If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1⊠M 2□ F Months Days Hours Min. 422-28-3592 72 11-20-1926 Missouri Usuel Residence of Decedent 10c. City, Town or Location 10a. Stata 10b. County 10d. Insida City Limits 1 X Yas 2 No N/A Baltimore City Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 W. Lake Avenue 21210 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 Xi Yes 2 W944-1946 I Yes, Give Year or Dates: 1948-1957 Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amaricen Indian, Black, Whita, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Catholic Priest Church 17. Fether's Name (First Middle Last) 18 Mother's Name (First Middle Maiden Sumeme) Calvin M. Sinclair Elizabeth Stepanek 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1130 N. Calvert Street Baltimore, MD St. Joseph Society Sacred Heart 21202 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 X Burlei 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery 1/29/99 Baltimore, Maryland 21. Signatury of Juneral Service Licansee Paul L. Hartsock, Jr. 22. Name end Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23e. Part 1. Enter the disease, or complications that calculations, or heart failure. List only one cause of the calculations. Approximata tnterval Between Onset and Death tha death. Do not enter the mode of dying, such as cerdiac or respiratory errest, PNEUMONIA Immediate Cause (Final 5 DAYS disease or condition resulting in deeth) Due to (or as a consequenca ot): Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to 24a. Was en eutopsy performad? completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) exeminer? Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner as ateted. 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one)

certificate be executed P.O. Box 68760 Records, Division of Vital Hospital or Attending Physician: 24 hours after death.

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

I Hygiene.

d 2 should be filed w th end Mental Hygier 7 Is marked other th

pemit. Pages 1 end 2 should be Department of Health end Mental Important: If item 27 is marked of any Injury or other traumatic ev

Physician

/Medical

Examiner

physician and the burial-tran

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page 2 has

certificate

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After

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Physician/Medical

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Medical To the Within 2

State Registrar

31. Dete tiled (Month, Day, Year) 7 1999

29b. Signature and title of certifier



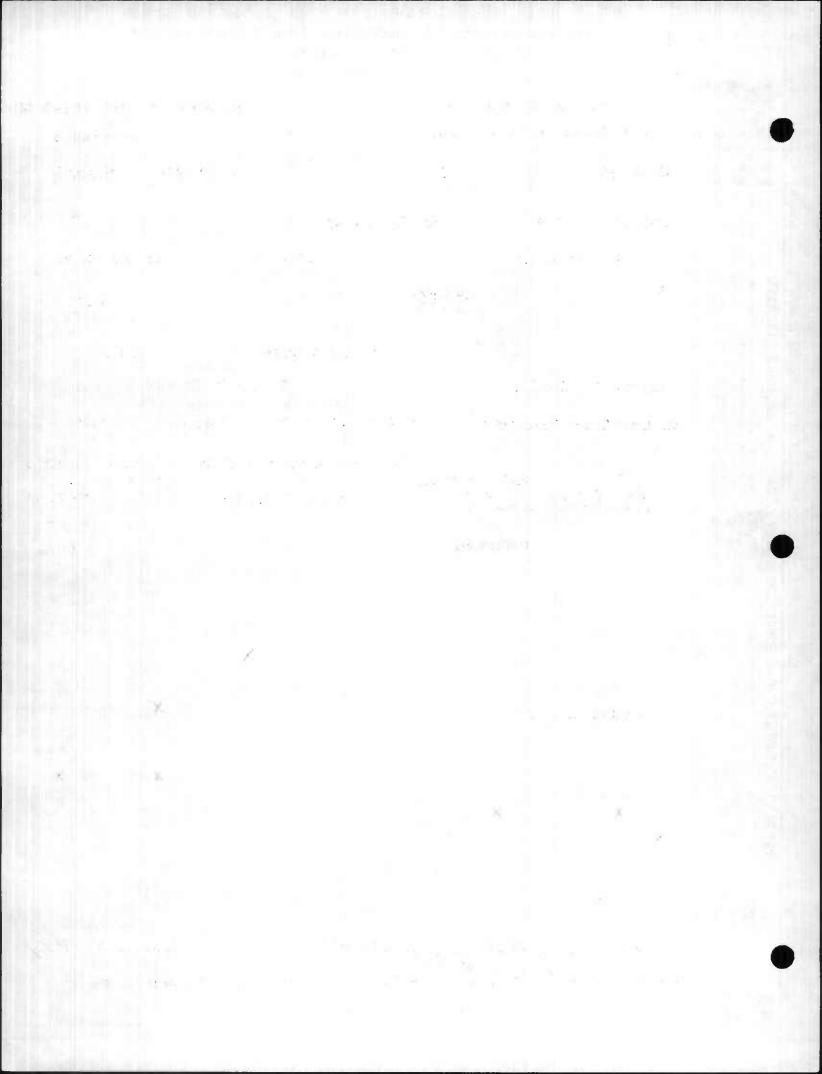
7601 OSLER DRIVE, TOWSON,

29c. Licansa number

D16492

29d. Date signed (Month, Day, Year)

MARYLAND 21204



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month Dey 25 1999 343 AM **Physician** Gilbert R. Saunders /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street and number) Examiner Anne Arundel North Arundel Hospital Glen Burnie If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplece (Stata or Foreign Country) Days 180 M 2□ F 58 Yrs. Nov. 10, 1940 Maryland 218-36-5325 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Linthicum 1 ☐ Yes 2 ☒ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 414 Cleveland Rd. 21090 United States 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 14. Raca - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 🖾 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) Dry Wall Mechanic Construction 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Doris E. Bartlett Gilbert A. Saunders 19e. Informent's Name/Raletionship (Typa, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Cleveland Rd., Linthicum, Maryland 21090 Doris E. Saunders/ Mother 20b. Pleca of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20e Method of Disposition Jan. 25 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from State Metro Crematory, Inc. 1999 Catonsville, Maryland 4 Donetion 5 Other (Specify) 22. Name end Address of Fecility 21. Signature of Edneral Service Licapsee Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 23e. PertT. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Onset and Deeth Immediate Ceusa (Finel CONGESTIVE HEART FAILURE (End Stage) diseese or condition rasulting in daath) Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or injury that initieted evants Due to (or es e consaquenca of): Physician/Medical that initieted evants resulting in death) Lest Due to (or as e consequenca of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably Winknown PNEUMONIA þ 24b. Were autopsy findings evallable prior to completion of cause of death? CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24e. Wes en autopsy SEIZURE DISORDER 1 Yes 2 No 1 Yes 20 No 25. Was casa rafarrad to medical exeminer? 26. Place of Death (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Data of Injury (Month, Day Year) 27. Manufer of Death 28b. Time of 28d. Describe how injury occurred Certification: Matural 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accident 281. Location (Streat and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. edicai 29a. Certifier.

certificate be axecuted Division of Vital Records, P.O. Box 68760, al or Attanding Physician: The safter death.

I Director: After this cartificate of in by the funaral director, pe 24 hours Hospital

Funeral

Director

than "natural", or items 23s or the Medical Examiner must be

Repartment of Health reportant: If Item 27

Physician /Medical

Examiner

physician and s the burial-trans

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To the Hosp within 24 hou To the Fune completaly fi Registrar

30. Name and eddrass of person who completed causa of deeth (Item 23e) (Type, Print) SHARLIF SAJID

29b. Signature

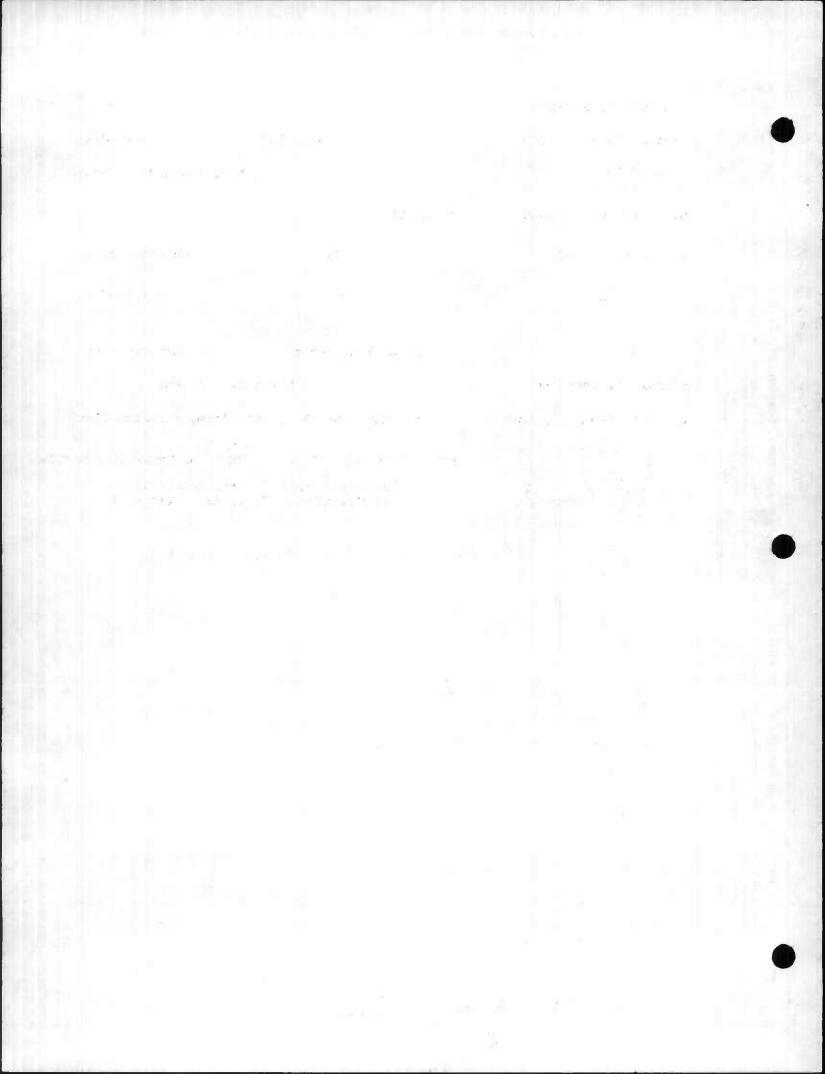


29c. Licanse number

5 1245

29d. Date signed (Month, Day, Year)

INNUARY 25,1999



State of Maryland / Department of Health and Mental Hy	ygiei	ne
Cartificate of Death	-	

					Cer	tifica	te of	Death	1		Reg. No.		
Physician /Medical	Decedent's Name (First, Mid HENRY A. STAU									2. Date of De Month JANUAF		999	3. Time of Death 3:00 P.M.
kaminer	4e Facility Name (If not institut	ion, give stre	et and numb	oer)		4b. City, Town, or Loc				cation of Deal	th 4c. County	of Death	37.
	1053 GENINE DRIVE							GLEN		E	ANNE	ARUN	DEL
eral tor	5. Social Security Number 213-18-1329	6. Sex	2□F 7.	Age (In yrs. 79	lest birthday) Yrs.	If Unde Months	Days	If Unde Hours	Min.	8. Date of Bi (Month, D Oct. 1	rth ey, Year) .6, 1919	9. Birthpi Coun Penn	lace (Stete or Foreign try) SYlvania
	Usuel Rasidance of Decedent			100 0	ty. Town or Lo								Od Analda Cibal Imina
rector	Maryland Anne		21		n Burn							"	0d. Inside City Limits 1 ☐ Yes 2 🖺 No
al Director	10e. Street and Number 1053 Genine Dr	ive					ip Code 060				10g. Citizen of tunited		
by Funeral	11. Marital Status 1 Never Married 2 M. 3 Widowed 4 Divorce	arried	Armed Forces?			Was Decedent of Hispenic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, € 1 ☐ Yes 2 No Specify:						ea - Americ ck, White, o	
Completed	(Specify only high	-			16e. Decedent's Usuai Occupation (Give kind of work dona during most of workil life. DO NOT use retired)					ng	16b. Kind of B	usiness/Inc	dustry
Comp	Elementary/Secondary (0-12 12)	Collega (1-4	or 5+)	Meat :			-,			Food P	roces	sing
To Be	17. Fathar's Name (First, Middle Karl Staude	e, Last)							ne Lo		e, <i>Maide</i> n Sumar	na)	
Ħ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19c. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1053 Genine Drive, Glen Burnie, Maryland 2106												
ance.	20a. Method of Disposition 1 Buriai 2 Cremation 4 Donation 5 Other		novai from St	ate	Placa of Disposemetery, crem	netory or	othar pla			an.27, 1999	20c. Location		wn, State , Maryland
9000	21. Signature of Funeral Service	e Licensee	2								ome, P. <i>I</i> n Burnie		21061
ian cal ner	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	a. <	CAR	D10	PUA or as a consag	uence of): _						Interval Between Onset end Deeth
an/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last	{ c. d. d	FAI	Due to (c	ARY or as a consequence or as a consequence of the	SE	UE				ry Iysei	MA	
d be detached for use	Part II. Other significant condi	tions contrib	outing to dea	th but not ras	sulting in tha ur	ndarlying	causa g	van in Part	l.		tobacco use co Yes 2□ No		the cause of death?
Completed by										24a. Wa	s an autopsy formed?	av	era autopsy findings aileble prior to mpletion of cause daath?
To Be Com										1 🗆	Yes 2 No	10	Yes 2 No
Be	25. Was casa raferrad to medie examiner?	_	nite!						e of Death	(Check only			
P	1 Yes 2 No		pital:		ER/Outpatien		JUA		lursing Ho		sidence 6 Dot		y)
cation:	27. Manner of Death 1 Natural 5 Pend 2 Accident investigation	ding stigation	28a. Date of (Month,	Dey Year)	28b. Tima of tnjury	м	28c. Inju	ny at ork?]Yes 2 [∠da. Dascribe	how injury occu	100	
5 =	3 ☐ Suicide 6 ☐ Coui	d not be mined				eet, facto	ry, office		1	28f. Location City or To	(Street end Num own, Stete)	ber or Aura	Il Route Number,
upletely filled in	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route No.												

State Registrar

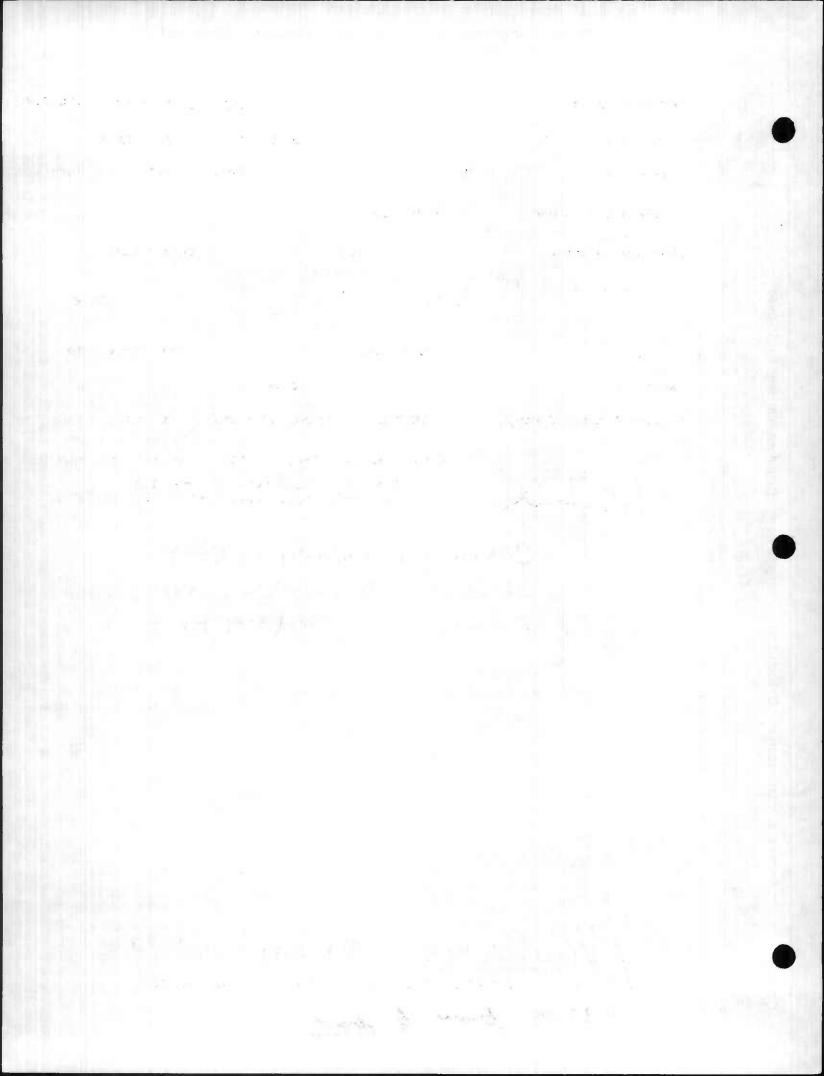
ALEGADO, M.D.

ELI B

implated causa of death (Itam 23a) (Type, Print)

3001 HANOVER ST., BALTIMORE, MARYLAND 21230

JANUARY 26, 1999



1. Decedent's Name (First, Middle, Last) 3. Time of Death 23,1999 **Physician** Stella 11:25am Sowienski Jan. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Towson Baltimore Birthplace (State or Foreign Country) 5. Social Sacurity Number If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-26-02 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 10M 27F 219-30-4140 96 Yrs PA **Director** Usual Residence of Decedent with the Maryland 10b. County Baltimore 10c. City, Town or Location 10d, Insida City Limits "naturel", or items 23s or 28s-f show adical Examiner must be notified at MD Rosedale 1 ☐ Yas 2 No Director 10e. Street and Number 1237 Landover Rd. 10g. Citizen of What Country? USA 10f. Zip Code 21237 pernit. Peges 1 and 2 should be filed within 72 hours efter deeth v. Department of Heelih and Menial Hyplene. Important: If item 27 is marked other than "naturel", or items 23a and Injury or other freumatic event, the Medical Environment page. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Yas 2 No If Yes, Giva X Year or Datas: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white PV 3 ☐Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usa retired) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maidan Sumama) Frances Krol 17. Father's Name (First, Middle, Last) Augustine Marshall Be To 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Francis Sowieski / son 1237 Landover Rd. Baltimore, MD 21237 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method ot Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify) Oak Lawn Cemetery 1-26-99 Baltimore, MD 21 Signature of Puneral Servica Linea 22. Name and Address of Facility Cvach/Rosedale Funeral Home 23a. Part1. Entar the disease, or complications that caused the disease. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart tailura. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in daath) /Medical BILATERAL PNEUMONIA 4 DAYS Examiner Due to (or as a consequence ot): Examiner DEHYDRATION 4-6 DAYS physician and the bunal-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated events rasulting in death) Last Due to (or as a consequence ot): Division of Vital Records, P.O. Box 68760, WEEKS MALNUTRITION Physician/Medical Dua to (or as a consequanca of) 88 for use as ATHEROSCLEROTIC VASCULAR DISEASE **YEARS** ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 20 No 3 Probably 4 Unknown by 24b. Ware autopsy tindings available prior to 24a. Was an autopsy performed? Completed s ueeq complation of cause of death? certificate hes b 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 25 No 1 N Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this funeral 27. Manner ot Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending death. 1 Yes 2 No n 24 hours after death.

Funeral Director: A pletely filled in by the fi Investigation 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 29a. Certifier Tacetifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the Vithin 2
To the Complei 29b. Signature and title of cartifian 29c. License number 29d. Date signed (Month, Day, Year) D48271

State Registrar

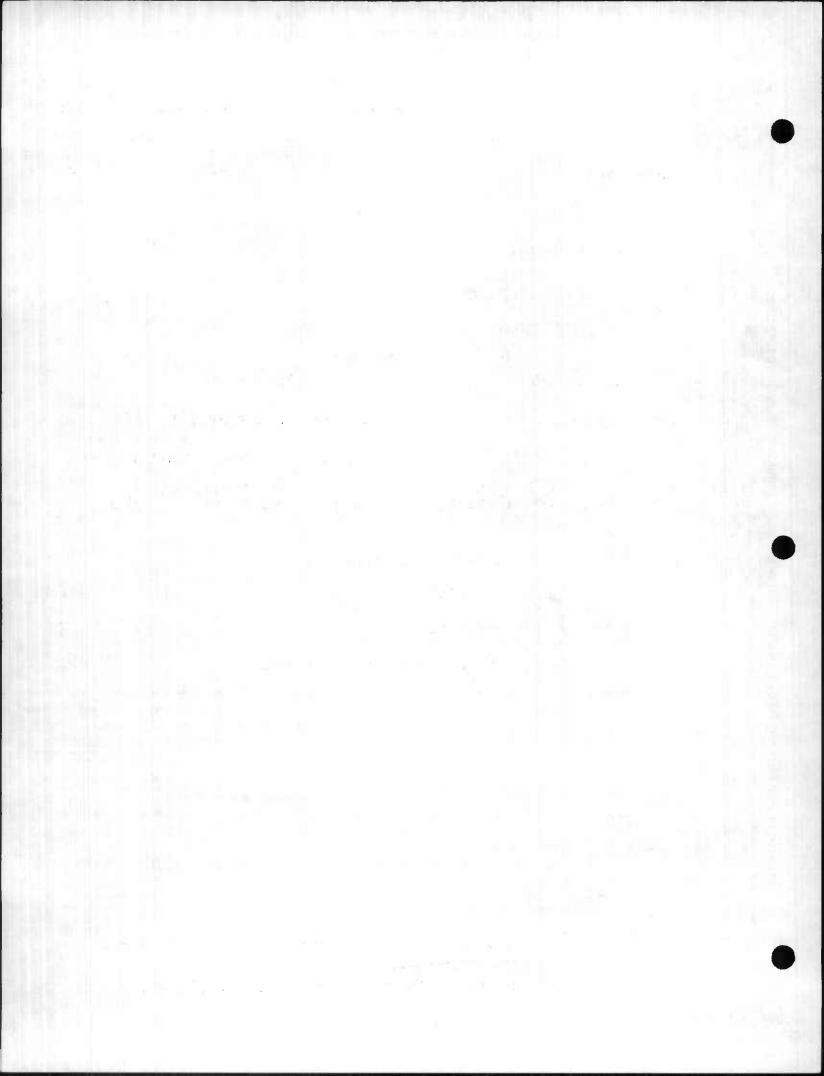
DHMH 16 Rev 6/95

7600 OSLER DRIVE SUITE 203, TOWSON, MARYLAND 21204 32. Ragistrar's Signatura

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

FAHED KOULI, M.D., 31. Date tiled (Month, Day, Year)

JAN 2 7 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

at at	O Date of Death
Certificate of L	Death Reg. No.
State of Maryland / Department of H	lealth and Mental Hygiene
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Physician /Medical Examiner

Funeral Director the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Director Funeral filed within 72 hours after altimore, Maryland 21215-0020 Aq Completed al Hygiena. traumatic event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 Is marked oths any Injury or other traumatic event DDGs. Be 0 **Physician** /Medicai **Examiner** Examiner physician and the bunal-transit Box 68760 certificate be Physician/Medical as esn he 5 signed t Records. PY Completed been page 2 has Division of Vital Be 2 Aftar this luneral Certification: I or Attending after death. Director: Aft Hospital of 24 hours a Funerel D edical To the I

1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Month Day Veer 1999 January 23, 1:16 A.M. Charles Spath Sr. 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death University of Maryland Medical System Baltimore 7. Age (In yrs. last birthday) 84 Yrs. If Under 1 Year | If Under 24 Hrs. | Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1XM 2□F 212-01-9376 2-11-14 MD Usual Residence of Decedent 10c. City, Town or Location 10d. inside City Limits 10a. State 10b. County MD Harford Bel Air 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 1602 Prindle Dr. 21015 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowad 4 □ Divorced Year or Dates: 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Crane Operator Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Gottlieb Spath Mary Berg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Spath Jr. / son 1602 Prindle Dr. Bel Air, MD 21015 20b. Plece of Disposition (Name of cometery, crematory or other place)
Holly Hill Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 17 Burial 2 Cremetion 3 Removel from Stete 1-26-99 Middle River, MD 21. Rignature of Funeral Service 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23a. Part1. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximata Interval Between Onsat end Death Immediate Ceuse (Finel disease or condition rasulting in daath) Aspiration Pneumonitis Due to (or as a consequence of): Penetrating Neck Injury 7½ days Sequantially list conditions, if eny, leading to Immediate causa. Entar Underlying Cause (Disease or Injury that Initiated events rasulting In death) Last Dua to (or as a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Left Common Carotid Pseudoaneurysm 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Approval 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? 26. Placa of Death (Check only one) Hospital: XXInpatient 2☐ ER/Outpatient 3☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1X Yas 2 No 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? 5 Pending Invastigation 1 Natural 1200 P M 1 Yas 2 No 2 Accident Jan. 15, 99 Stabbed self in the neck 6 Could not be datarmined Location (Street and Number or Rural Route Number, City or Town, State) 1602 Prindle Drive, 3 ☐ Suicida 4 ☐ Homicide 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) Home HOME Belair, Maryland 21015

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha ceusa(s) and manner as stated. 29a. Certifi Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Year)



Registrar

State

31. Date filed (Month, Day, Year) JAN 27 1999

WYCE, MD 32. Registrar's Signature

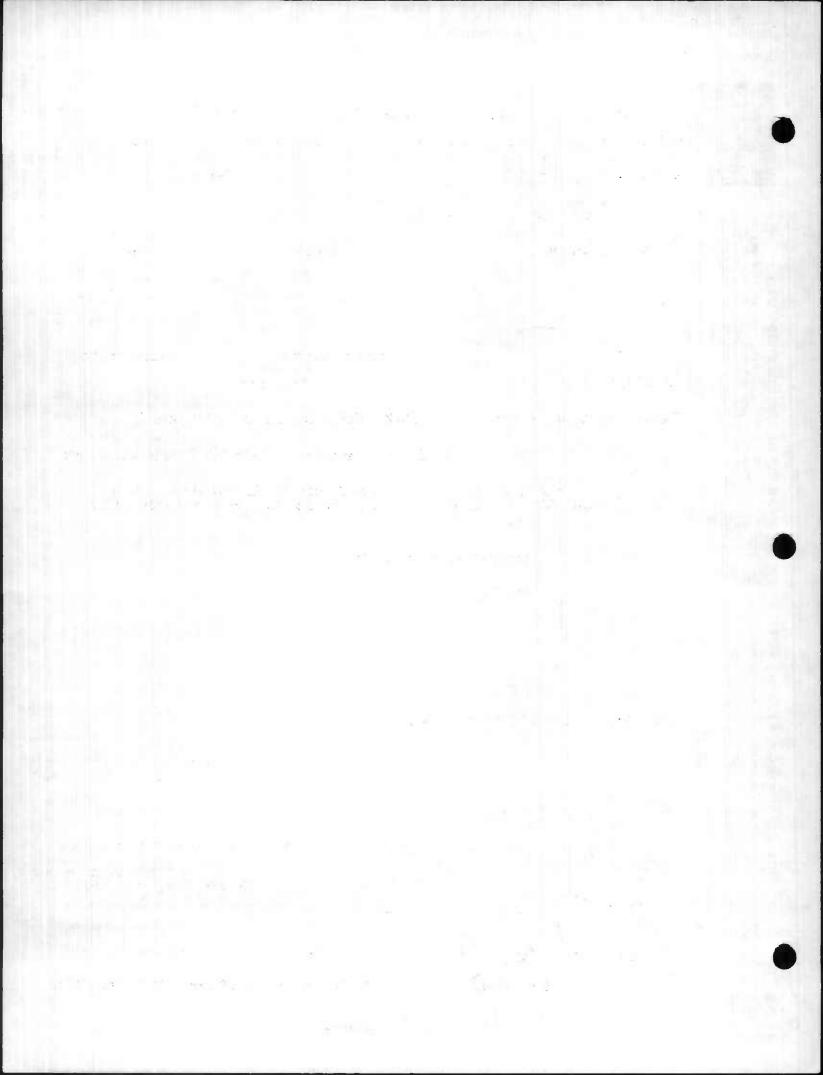
ne and address of person who completed ceuse of death (Item 23a) (Type, Print)

Sports

O.C.M.E.

January 24, 1999

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

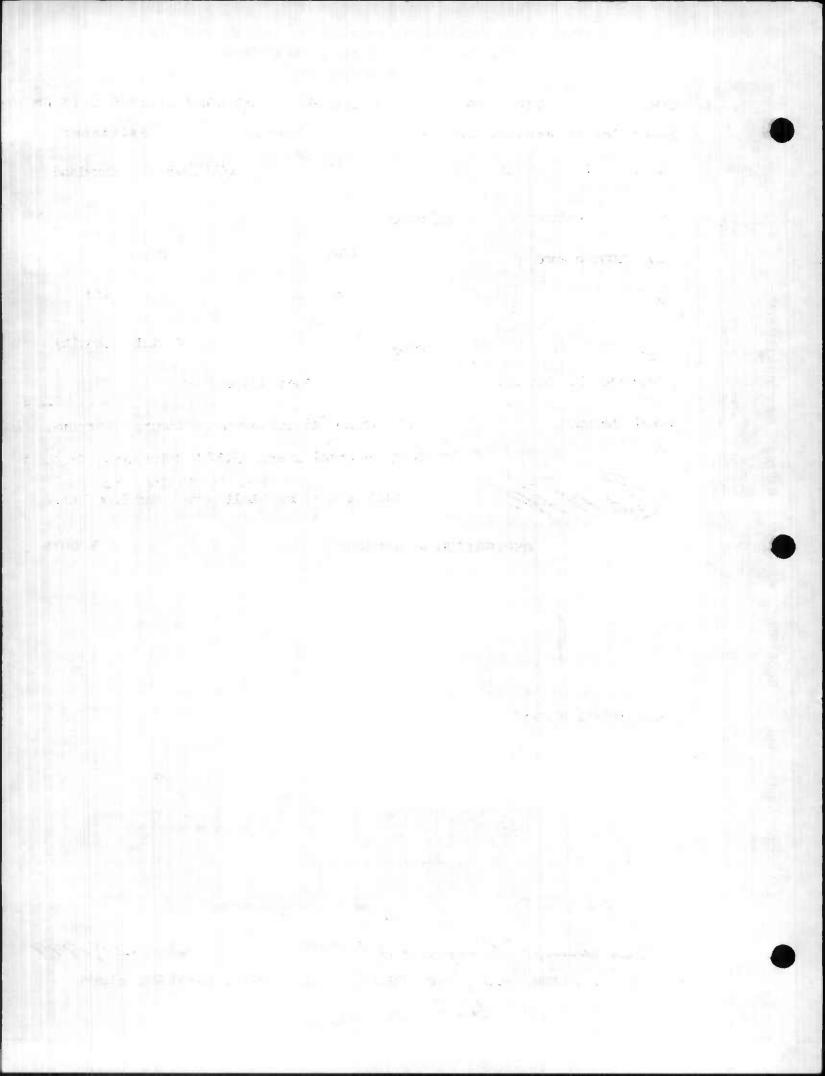
		State			tifica	ite of	Death			eg. No.	99 (T-126.1
Physician /Medical	Decedent's Neme (First, Middle ETHEL	VIRGI	NIA	S	CHE	_HAU	SE	J	2. Dete of Deel	Dey 1		Time of Deeth
Examiner	4a Facility Neme (If not institution Saint Joseph	n, giva street and n Medica	umber) 1 Cent	er				WSOT	ocation of Deeth	4c. County of Deeth Baltimore		
Funeral Director	5. Social Security Number 218-18-9052	6. Sex 1 ☐ M 2 ☐ ★F	7. Age (In yrs. 74	. last birthday) Yrs.	If Und Month	ler 1 Yaar s Deys		Min.	8. Dete of Birth Month, Day	925	9. Birthplace Country) Mary.	(Stete or Foreign
A show	Usual Rasidenca of Decedent 10e. Stete 10b. County MD Bal	timore	imore Baltimore									Inside City Limits
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mpi	15. Deceden (Specify only higher Elementary/Secondary (0-12)	st grada completed	() (1-4or 5+)	1-4or 5+) 16e. Decedent's Usual Occupation (Giva kind of work done during most of work life. DO NOT use retired) Clerk				st of work	ing	Social	usiness/indust	
d out	17. Fethar's Name (First, Middle, Last) Frederick W. Abt Sr. 18. Mother's Name (First, Middle, Meiden Sumeme, Anna Dixon								ne)			
es 1 and 2 sin of Health and f item 27 ie m r other freum	Ethel Langtor 20e. Method of Disposition	20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)									Mary City or Town,	yland Stete
permit. Pag Departmant Important: h any injury o ance.	4 Donetion 5 Other (S	pecify)	IND.	64	2. Na <i>m</i> e	end Addr B el ai	ess of Fecil	ity Joh	n C. Maltimore	Miller e, Mar	Inc.	Maryland 21206 proximete
Physician /Medical Examiner	23a. Penti-Enter the diseese, or shock, or heart feilure. List Immediate Cause (Finel disaesa or condition resulting in deeth)		RATION		MON	IA	mg, such es	Startiet	or respiretory en	651,	Int	ervel Between eset and Death DAYS
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this carificated director,	exeminer?	Hospitel:	Inpatiant 2	☐ ER/Outpetler	nt 3□	000	hor		ome 5 Resid		har (Specify)	
Attending Priny or death. •ctor: After this by the funeral d	27. Manner of Death 1 X Naturel 5 Pendin 2 Accident Investig	28e. Dat (Mc	e of Injury onth, Dey Year)	28b. Time o		28c. Inju			28d. Describe h			
Cert	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicide determ	ined 288. Fla	ce of Injury - At I ding, etc. (Spec		reet, fect	ory, office			28f, Location (S City or Tow	itreet end Num n, State)	ber or Rural Re	oute Number,
24 hoursteely fill dical		g Phyelclan: To the Examiner: On the end me										
Med Med	29b. Signeture end title of certifie					29c. Licen	se number		2	29d. Dete signo	ed (Month, De)	r, Year)

State Registrar

32. Registrer's Signeture

Beatring P. Dinger M.O. D 16492

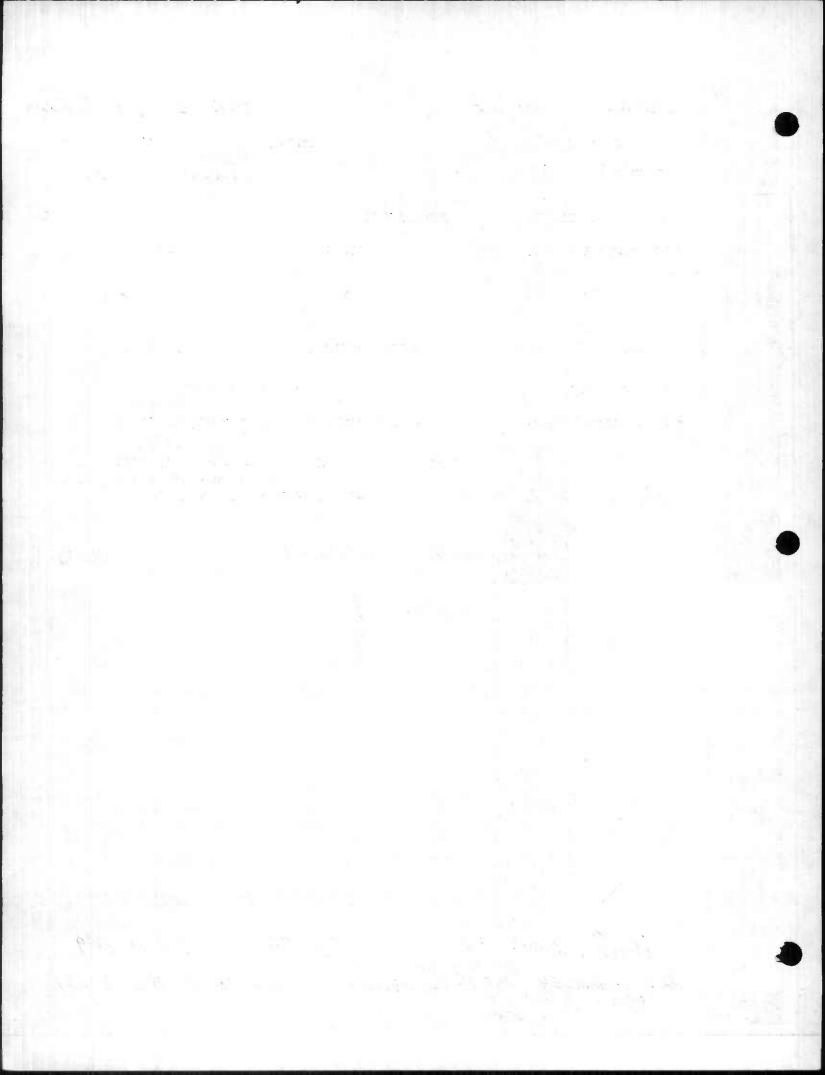
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
BEATRIZ F. DIZON, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 5:05 PM emmie MAT /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner CHURCH HOME HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. lest birthday). Birthpiace (State or Foreign Country) 100 M 2□ F Deys Hours 213-16-7654 Yrs. Director N.C Usual Residence of Deceden 10a. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or items 23s or 25a-f show must be notified at Director RANDALLSTOWN 1 ☐ Yes 2XXNo MD. BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? USA 21133 9703 MARYSVILLE RD. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. Baltimore/Marwand 20275-0980AN filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 Ĭ No Specify: by Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) POLICE OFFICER HOSPITAL 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Departmetizer Health and Mental Important: If then 27 is marked on any injury or other traumetic even 8 Pages 1 and 2 should JESSIE TAYLOR ISADORA McGLONE 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 9703 MARYSVILLE RD BALTIMORE, MD 21133 MILDRED GOODE (NIECE) 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) 1-28-99 KING MEMORIAL PARK BALTIMORE, MD 21. Signefure of Funeral Service Licenses 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. DecTr CASP 1721-27 N. MONROE ST. BALTIMORE, MD 21217 23a. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Physician /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In deeth) Lasf Due to (or es e consequence of) Box 68760. physician s the buriel Physician/Medicai Due to (or es e consequence of): P.O. been signed by the a should be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 2 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Wes an autopsy performed? page 2 s 1 □ Yes 2 No this certificate 1 Yes Division of Vital or Attending Physician: director. 25. Was case referred to medicel exeminer? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA In by the funeral 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After 1 Neturel 5 Pending investigation 1 Yes 2 No 24 hours after death. 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, sfreet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 1 Certifying Phyaician: To the best of my knowledge, deeth occurred ef the time, dete end plece, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner steted. Medical 29a. Certifier within 2 ŝ 29b. Signature/End title of a 29d. Defe signed (Month, Day, Year) of person who completed ause of death (Item 23e) (Type, Print) BALTIMONE MD 31. Dete filedi 32. Registrer's Signeture State Registrar



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certificate

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To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

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Certification:

Box 68760

P.O. 1

Records.

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be flied withir Department of Health and Mental Hygiena. Important: If flem 27 is marked other than any injury or other traumatic avant

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28a. Deta of Injury (Month, Day Year)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28a. Placa of Injury - At home, farm, street, fectory, office building, atc. (Specify)

M.D

28c. Injury at Work? 1 Tas 2 No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end mannar as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

29b. Signature-and title of certific 30. Name and address of person who complated cause of deeth (Itam 23a) (Type, Print)
PERFECTO C. VALAR AD M.D

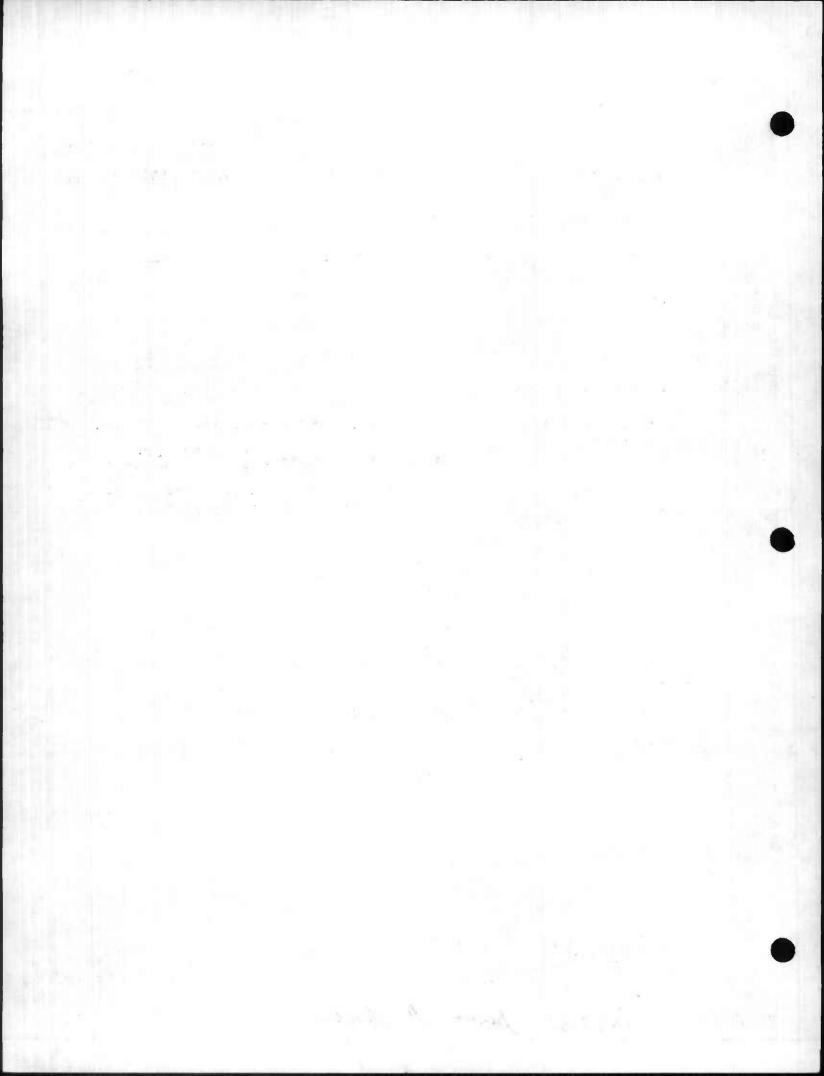
29c. Licanse number D16389

29d. Date signed (Month, Day, Year) 17 16 HARFORD ROAD ROOM 106 PAUSTON A

31. Data filed (Month, Day, Year)

32. Registrar's Signature

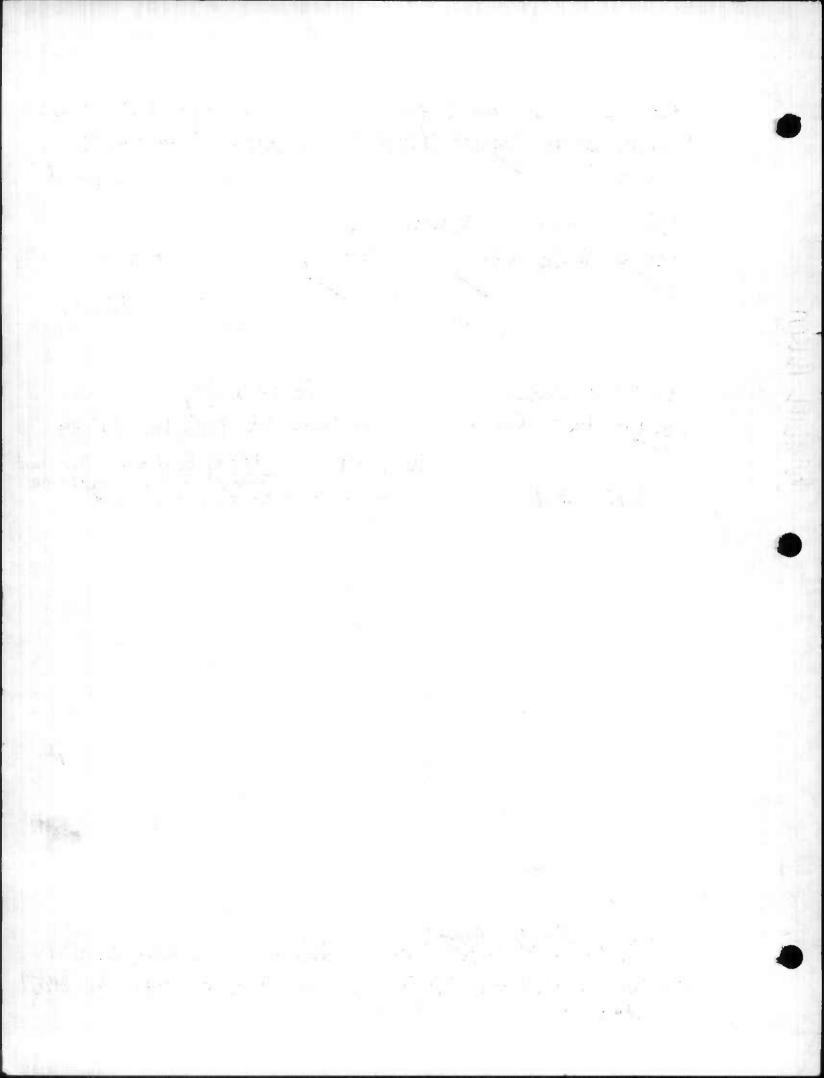
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

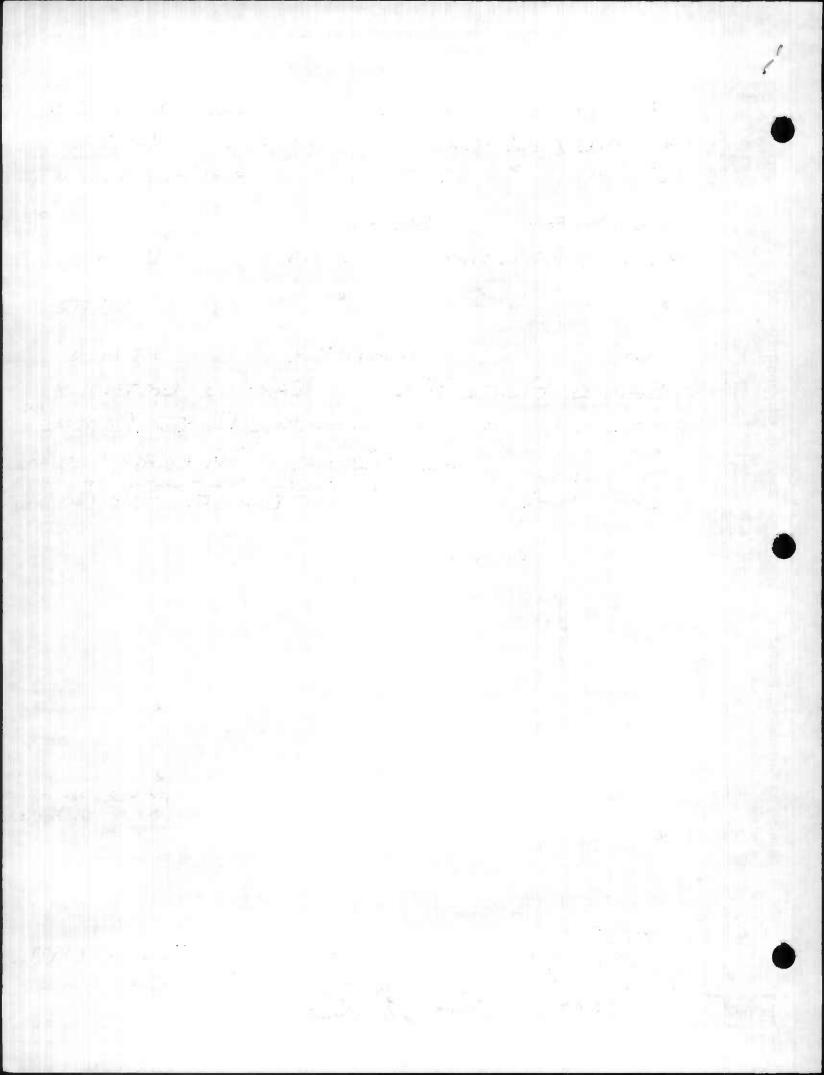
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ter de	Items Inst. m	Funeral	11. Meritei Safus 1 Never Merried 2 Married	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of If Yes, specify Cul	Hispanic Orlgln? (Spe ben Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American in , White, etc.	idien,
21215-0020 within 72 hours after	- 3	þ	3 Widowed 4 Divorced	If Yes, Give Yeer or Detes:	1 Yes 2 10 No	Specify:		Specify:	Bla	ch
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vision of Vital Records, P.O. Box Attending Physician: The law requires that the death cer	is been signed by the attendir 2 should be detached for use	P.					1 ☐ Yes	210 No :	3 Probebly	y 4 □ Unknown
rds	on sign	Completed by					24a. Wes an e	outopsy	24b. Wera a	utopsy findings le prior to
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Divisio To the Hospital or Attendi	To the Funeral Director: After thi completely filled in by the funeral		29b. Signature and title of gediting	1. Attend	29c. Licer	nse number	29d.	. Dete signed	(Month, Dey,	Year)
			Harry De	le phy	Trida)	42595	Ja	nuarv	18,	999
			Neme end accress of person who cor	mpleted cause of deeth (Item 2	3a) (Type, Print)	Ornan Dr	ina Rai	tion	0 1/	0 01020
	Stat	e	31. Dete filed (Manth, Dey, Year)	32 Registrer's Signetur	V HWIKHII	symme DI	ive ba	ltimoi	O IVI	N LILDI
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Name (First, Middle, Last) Month **Physician** JANUARY 20, 1999 ation of Death 4c. County of Death 2:0081 Sis AOM: /Medical 4b. City, Town, or Location of Deeth 4e Fecility Nema (If not institution, give street and number) Examiner 4112 OM ORK If Under 24 Hrs. 8. Date HARFORD DAC If Undar 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys Hours Min. 1 M 28 F Yrs AUG.11, 1909 89 Director 223 12 1061 Usual Rasidance of Dacedant the Marylenc 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, its Medical Examiner must be notified at 1 ☐ Yas 25 No Director MARVLAND HARFORC 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? with 41016 0 ROADWAY Funeral death 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11, Marital Status Black, White, atc. Pages 1 and 2 should be filed within 72 hours effer nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or ite 1 ☐ Yas 2 No If Yes, Give Yeer or Detes: 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: ò 3. Widowed 4 ☐ Divorced TIKW Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) HOMENAKER AT Home 12785 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be BOT AROLINE Tom SAMUEL 2 12 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 11116 YORK LARYLAND FRANCES 4112 010 other t LOUKION 20c. Location - City or Town, State 20b. Place of Disposition (Nama of cematary, cramatory or other place) JAN 23 20a. Mathod of Disposition 18 Burial 2 Cramation 3 Ramoval from State 0 permit. Page Department of Important: If any Injury of 4 ☐ Donation 5 ☐ Other (Specify) 1999 (EMORIA) LAND 22. Nama and Address of Facility CHAPE 21. Signature of Funeral Service Liber BULAIR P.A. 21020 3 REWPORT DRIVE PARYLAND 23a. Part1. Entar the disease, or complications that cause that cause that death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CEREBRO UNSCUI AN Examiner Due to (or as a consequence of) Examiner physician end the buriel-transit Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as e consequance of): P.O. Box 68760, certificate be Physician/Medicai Dua to (or as a consequence of) 88 esn for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? detached signed by ti 1 Tan 25 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wera autopsy findings available prior to completion of cause of daeth? Completed 24a. Was an autopsy performed? peeu page 2 s certificate has 255 No 1 ☐ Yas 2 ☐ No director, 25. Was case rafarred to madical axaminar? Be 26. Place of Death (Check only one) AT HIR GRAND AUGHT Hospital: Other: 4 Nursing Homa 5 Residence 6 BOther (Specify) SR'S Home 1 Yas 25 No 0 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28d. Dascribe how Injury occurred 27. Mannar of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Panding invastigation 1 Natural Attending after death. Director: Aft 1 TYas 2 No 2 Accident 6 Could not ba datarmined 3 Sulcida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homicida ò 24 hours a Hospital ts. Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title/fit certifie 29c. Licansa number 29d. Data signed (Month, Day, Year) 301 9 address of person with completed causa of daath (Itam 23a) (Type, Print) M 3346 32. Ragiftrar's Signature State Registrar

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BALTIMORE, MARYLAND 21215-0020 Welch, Julin

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fter death. Page 6 may be retained by the hospital or attending physician,	the funeral director, page 5 should be detached for use as the burtal-transit permit. Pages 1, 2, 3 should oval.	al examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

	1 - STATE REGISTRAR	SIAIE UF I	WARYLAND /				DEAT			TYGIEN! REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Julia Elizabeth		-						2. DATE OF Januar	DEATH		1999	3. TIME OF DEATH 3:35PM
	4. SOCIAL SECURITY NUMBER 213–10–7725	5. SEX	6. AGE (In yrs. lest	t birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, Do NOV . O.	BIRTH 9/ Year) 3 1909)	a. BIRTHE	PLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give Wesley Home	atreet and number)				r, rown c altim	ore	ON OF DE				NTY OF DE	
DIRECTOR	10e, STATE 10b, COUNT N/A	TY		10c. CITY, TOWN OR LOCATION Baltimore									10d. INSIDE CITY LIMITS?
FUNERAL C	100. STREET AND NUMBER 2211 Rogers Ave.			<u> </u>		101	. ZIP CODI	209	-	10g. CITIZEN OF WHA			1 X YES 2 NO HAT COUNTRY? USA
B∀	11. MARITAL STATUS 1 [A Never Married 2 Married 3 Widowed 4 Divorced		TEVER IN U.S. ARI	2 NO If yes, specify Cuban, Maxican, Puar					i, Puarto Rica	ORIGIN? (Specify Yea or No— 14, RACE — Black, \ Specify:			- American Indian, White atc.
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 12	(Gr	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use nettred.) Sales					166. KIND OF BUSINESS/INDUSTRY Retail					
BE CON	17. FATHER'S NAME (First, Middle, Last) Elias Welch		, ,				18. MOTI	Mary	Tice	lle, Maiden :	Sumame)		_
TO B	190. INFORMANT'S NAME (Type/Print) Mrs. Lucile Shaw/ Frie	end	19b						, MD. 2		n, State, Zip	Code)	
	20a. METHOD OF DISPOSITION 1 \(\times \text{Burlel 2} \) Cremation 3 \(\text{Ren} \) Ren 4 \(\text{Donation} \) Donation 5 \(\text{Other (Specify)} \)	20b. PLACE A		etery			_	-26-99	Wood	llawn,		n, State	
	21. SIGNATURE OF PUMERAL BERVICE L	PS	_				1050	York I	Tuner Rd. Tow	son, M	W. 21	.204	
	23. PART I. Enter the diseases of shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a CH	use on each lina.			tha mo	da of dyl	ng, such	an cardled	or reaple	ratory ar	reat,	Approximata Interval Between Onset and Death
LION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	cDUE TO	(OR AS A CONSEO	A CONSEQUENCE OF):									
AL C	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMILIANI F PRICE TO												WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
PHYSICIAN: MEDICAL	Domestici	IDIDLITE TO CA	LICE OF DEAL	W11 3/1			1			YES 2	NO		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
Sic	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE!	R: sing Hom	• 5 🗆 Ra	sidence (8 Other (Sp	pecify)			
ву РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF (Month, D	Pay, Year)		JURY M	1 🗆 1	PK?	NO	28d. DESCRI	BE HOW IN	JURY OC	CURED	
	3 Suicide 8 Could not be 4 Homicide datermined	building,	of INJURY — At hor etc. (Specify)							own, State)			ute Number,
COMPLETE		ER: On the beals of a					eath occur	ed at the P	lme, deta and				and manner as stated.
TO BE	296. SIGNATURE AND PLE OF CERTIFIE R. Julit, N 30. NAME AND ADDRESS OF PERSON WI	S .					29c. LICE	d/Y	6×		29d. DAT	1/25	Month, Day, Year)
	ROBERT LIBERTO	3108 1	sank 5	27) (Type		170	n	ul	2/2	Zx			
ROBERT LIBERTO 3508 BANK ST BALTO, MI 2/22x 31. DATE FILED (MANIN 100) YOUR 1999 32. REGISTRAR'S SIGNATURE G. Sparks													

CHE

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death Month 3. Time of Death Year **Physician** Williams Gametta 4b. City, Town, or Location of Death 4c. County of Death 25 1999 8:55 AM /Medical 4e Facility Name (If not institution, give street end number) Examiner Baltimore Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Months, Deys | Hours | Min. | 04/12/1954 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□ M 2♥ F Vrs 219-62-7127 Director 44 Maryland Usual Rasidence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No MD. Baltimore Lansdowne Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1921 Victory Drive Funeral 21227 United States 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 M Merried 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes No Specify: Specify: White p 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health 12 Nurses Aide 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ae 0 William David Stewart Lillian Burtha Martin permit. Pages 1 and 2 ah. Department of Health and Important: If them 27 is me. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian B. Lilley - Mother 1920 Griffis Ave. Baltimore, Maryland 21230 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Steta 1 Buriai 2 □ Cremetion 3 □ Ramoval from Stete Loudon Park Cemetery 1/29/99 Baltimore, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Fecility Ambrose Funeral Home Inc. 21227 1328 Sulphur Spring Rd. Arbutus, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel Gastric Metastatic 2 morths disease or condition resulting In deeth) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medicai Dua to (or es a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown rulmonary Embolus à 24b. Were eutopsy tindings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 No 25. Wes case reterred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ZENo Medicai Certification: To 27. Manner of Death 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated. 29a. Certifier

be axecuted Box 68760. P.O. Records. Division of Vital

attending physician and for use as the burial-tran signed by t peen cartificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartifical lately filled in by the funeral director. To the To the To the F

"natural", or hems 23s or 25s-f show

Hygiene.

2 should be ! and Mental ? is marked of

altimore, Maryland 21215-0020

State

Registrar

31. Date filed (Month, Dey, Year)

29b. Signatura and titla of cartifier

(Check only one)

Abenaa Brewster 32 Registrer's Signeture

der mo

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print)

Johns Hopkins Hospital Dave.

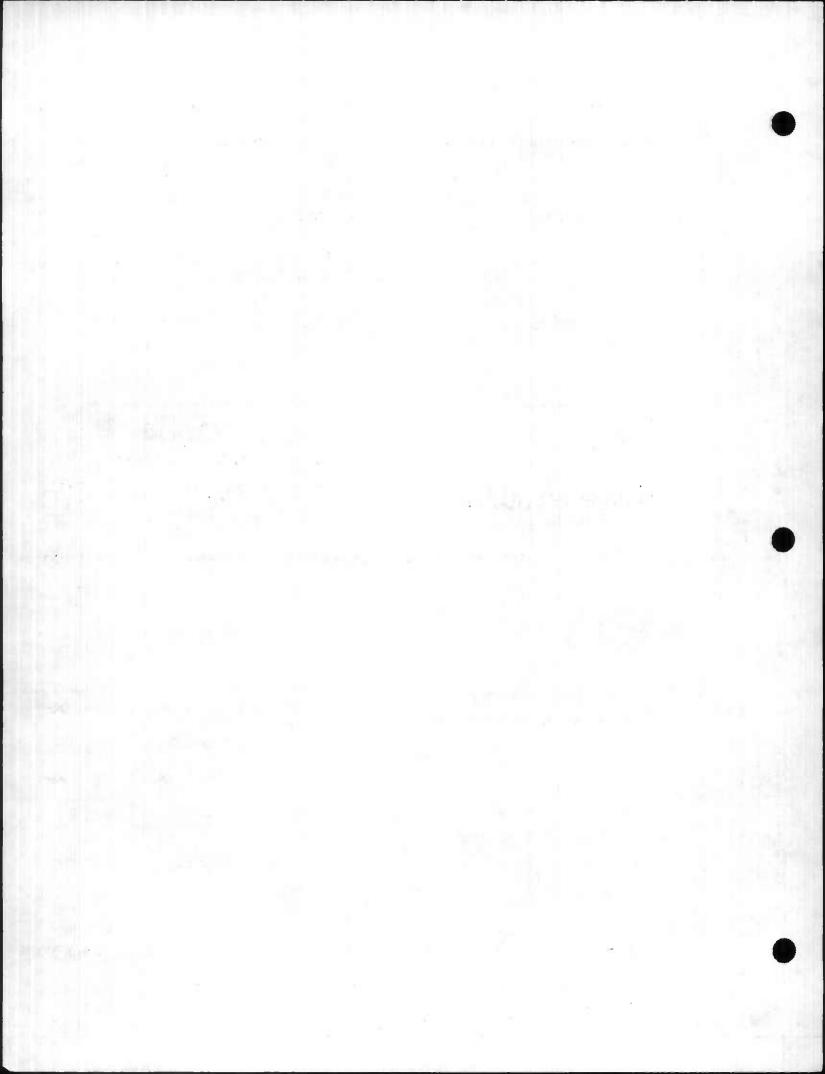
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

PPPPI, 25, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death OTPA Month Physician Linda Charmaine Watkins JANUARY 22,1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice- Mercy Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 Months 213-72-1889 41 Director Nov. 20, 1957 Usual Residance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Md. n/a Baltimore Director No Yes 2 □ No 28a-t 10e Street and Number 10f Zin Code 10g, Citizen of What Country? Name 23a or 3349 Windsor Avenue 21216 USA Funeral 13. Was Decedeni of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status 12. Wes Decedeni Ever in U.S. Armed Forces? 14. Raca - American Indian, Black, White, etc. 1 Yes 2 No 1 Never Merried 2 Merried "natural", or 1 ☐ Yes 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiere. Elementery/Secondery (0-12) College (1-4or 5+) 3 1/2 Human Resources Director Harbor Bank reportant: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Benjamin T. Cannon Mary Cousar 19a. Informant's Name/Ralationship (Type, Print) mother 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Cannon 3349 Windsor Avenue Baltimore, Md. 21216 20b. Place of Disposition (Name of cametery, crematory or other placa) 20a. Mathod oi Disposition 20c. Location - City or Town, State 1 ☑ Rurial 2 ☐ Cremation 3 ☐ Removal from State Jan. 27Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 22. Name and Address of Facility 21. Signature of Funeral Service Licegue Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 23a. Part 1. Enter the diseasa, or complications that can shock, or heart lailura. List only one cause on each the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Batween Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Carsinoma Examiner Due to (or as e consequenca of): Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of). Physician/Medical Dua to (or as a consequenca oi): the 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown bengis d be del þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 200NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be MARIS AT MERCY 26. Place of Death (Check only one)STE//A Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) HOS Dice 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date oi Injury (Month, Day Year) 27. Manner oi Death 28d. Describe how injury occurred 28b. Time oi 28c. Injury at Work? 1 Naturel 2 Accident 5 Panding 1 ☐ Yas 2 ☐ No investigation To the Hospital or Attendi within 24 hours after deeth To the Funeral Director: A completely filled in by the f 6 ☐ Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Cartifiar (Check only one) 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

P.O. Records, Division of Vital Attending deeth.

be exect

Box 68760.

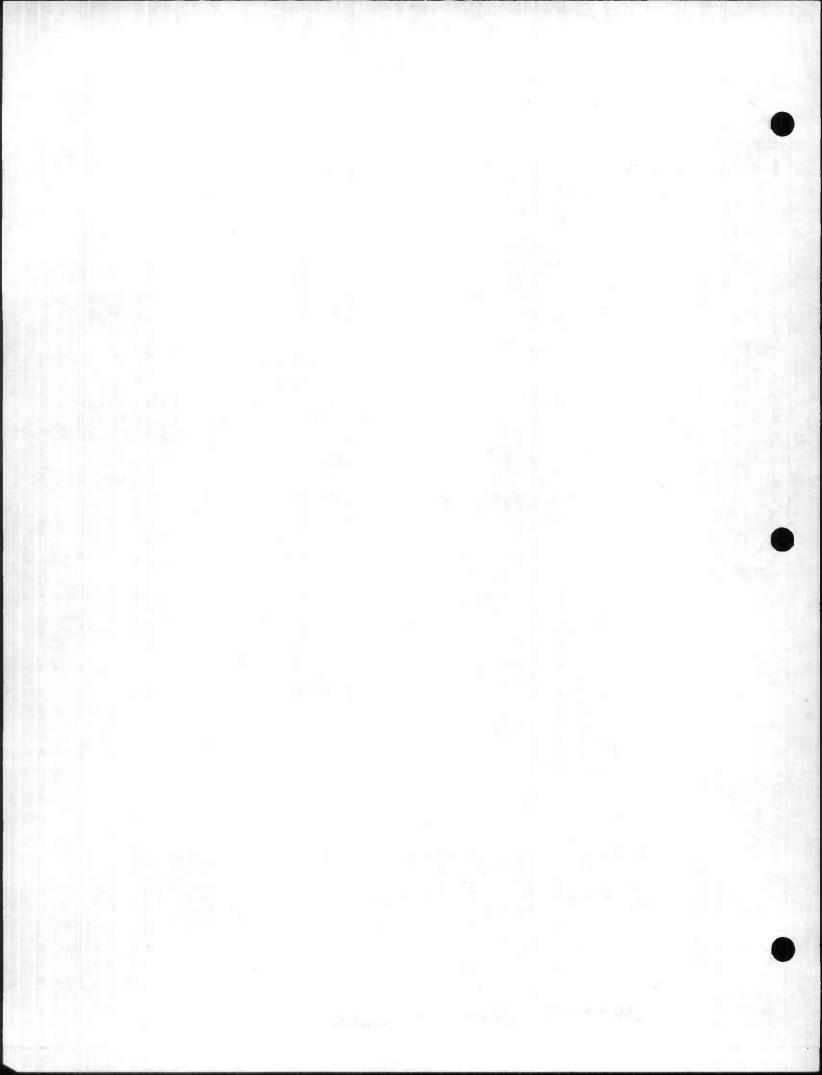
8 and Mental

> State Registrar

RISEBERG DAVID 31. Date filed (Month, Day, Year) JAN 2 7 1999

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 301 St Registrar's Signature

BAHIMORE MD 21202

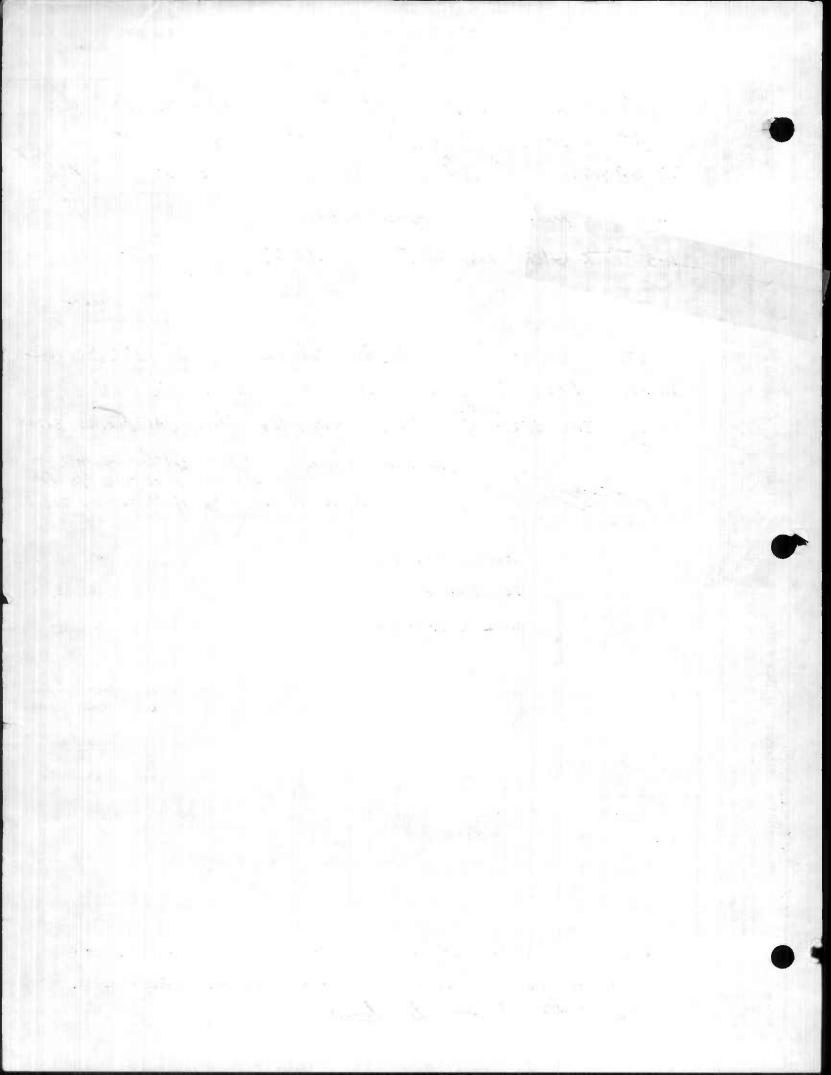


	State of Maryla								
1. Decedent'e Name (First, Middle, Last)			,				3. Time of Death		
WaNda	601115	e 111	aLTI	rabl	-	y 26, 19	999 0032		
4a Facility Neme (If not Institution, give	street end number)			4b. City, Town, or I	ocation of Deeth				
ST. AGNE	es 405,	pital		BAM	More	- 1	M		
211 22 242 15		Mo			(Month, De)	, Year)	9. Birthplece (State or Foreign Country)		
415-88-7952	34	118.			1-21	-65	1419		
10a. Stete 10b. County	10c. C	City, Town or Location	on				10d. Inside City Limits		
MD NA		BALTI	mor	e			1€ Yes 2 No		
10e. Street and Number		1	Of. Zip Code			10g. Citizen of W	hat Country?		
105 Rock Gle	N Road H	AT T	J 21229			1151	4		
	12. Was Decedent Ever in	U,S. 13. Wes	Decedent of	Hispenic Origin? (S	pecify Yes or No-	14. Rece	- American Indien, k, White, etc.		
1 Never Married 2 Married	1 ☐ Yes 2 ☐ No				o mount oron		11 11		
3 Widowed 4 Divorced	Yeer or Detes:						Diace		
15. Decedent's Edu (Specify only highest gred	cation e completed)	16a. Decedent's Usuel Occu (Give kind of work done		ccupation lone during most of working		16b. Kind of Bu	siness/Industry		
Elementery/Secondery (0-12)	College (1-4or 5+)	007	VOT USE retire	01 1		116 0=	TI Commire		
17 Fathar's Name (First Middle Last)		1031	al		ne (First, Middle,	Maiden Sumem	al service		
- /-	land later	1+hall 6	-	Many	Alico	11/0/11	1/211		
		19b. Meiling A	ddress (Stree	et end Number or Ru	iral Route Number	or, City or Town,	Stete, Zip Code)		
n.1. 11:00		73 5	nn	non lev	Street	RAUTIN	war, MD. 21229		
20e. Method of Disposition	City or Town, Stete								
1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Loudon Park 1-30-99 BALTimore, M									
	11.0 7/4 PA								
m	ms -	10	0 1	101	CI	DAITE	1014 17 71717		
23a. Part1. Entar tha disaasa, or compl	ications that caused the de	eth. Do not enter th	e mode of dy	ring, such es cardia	or respiretory er	A STATE OF THE STA	Approximate		
shock, or heart failure. List only or	na cause on each line.						Intervel Betwean Onset end Death		
Immediata Causa (Final	Cardian Am	rhathmic					15 minutas		
resulting in death)			ca of):				45 minutes		
							1-2 days		
U.									
rany, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Lupus ervt	hematosis					4 years		
thet initieted events resulting in deeth) Lest			- 0				1		
	4								
Pert II. Other significent conditions con	ntributing to death but not re	esulting in the under	tying cause g	given In Pert I.			ntribute to the cause of death?		
					10	Yes 2 No	3 Probably 4 Unknown		
					24e. Wes	en eutopsv	24b. Wara sutopsy findings		
					perfo	rmed?	aveilable prior to complation of cause of death?		
							1 ☑ Yes 2 ☐ No		
25. Was case raferrad to medical exeminer?	lospitel:		O	Whore	ath (Check only o		(0		
	1 inpatient 2		BLI DUA	4 Nursing F	lome 5 Resident	how injury occurr			
TE TOS ZENO	28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury Work?			ork? □ Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,			
27. Manner of Deeth 1 Manual 5 □ Pending	(Month, Dey Year)		M 1						
27. Manner of Deeth 1 St Neturel 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be					28f. Location (Street end Numb	er or Rurel Route Number,		
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27. Manner of Deeth 1 Neturel	28e. Place of Injury - At building, etc. (Special Control of March 1997)	home, ferm, street, cify)	fectory, office	e time, date end plece	City or To	vn, Stete) ceuse(s) end ma	nnar as stated.		
27. Manner of Deeth 1 Neturel	28e. Place of Injury - At	home, ferm, street, cify)	fectory, office	e time, date end plece	City or To	vn, Stete) ceuse(s) end ma	nnar as stated.		
27. Manner of Deeth 1 50 Neturel 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only) 27. Meanner of Deeth 1 50 Neturel 1 50 Pending Investigation 6 Could not be determined	28e. Place of Injury - At building, etc. (Special Special Spec	home, ferm, street, cify)	fectory, office curred et the igation, in my	e time, date end plece	City or Ton e, end due to tha urred at the time,	ceuse(s) end ma dete end place, s	nnar as stated.		
27. Manner of Deeth 1	28e. Place of Injury - At building, etc. (Special Special Spec	home, ferm, street, cify) nowledga, daath ocnation and/or invest	fectory, office curred et the igation, in my	e time, date end plece r opinion, daath occur nse number	e, end due to tha	ceuse(s) end ma dete end place, s 29d. Dete signed	innar as stated. and due to the cause(s)		
	4a Facility Neme (Il not institution, give in the property of	Usuel Residence of Decedent 10a. Stete 10b. County 10c. Co 10c. Street and Number 10 Secured Married 11. Marital Status 12. Was Decedent Ever in Armed Forces? 1. Decedent'e Name (First, Middle, Last) 4a Facility Neme (If not institution, give street end number) 5. Social Security Number 6. Sex 7. Age (In irs. lest birthday) 10a. Stele 10b. County MD 10c. City, Town or Location 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wes Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. 13. Wes Armed Forces? 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) 17. Fathar's Neme (First, Middle, Last) 19a. Informent's Name/Ralationship (Type, Print) 19b. Melling A 10b. Place of Disposition 1 Burlel 20c. Method of Disposition 1 Burlel 21. Signeture of Funerel Service Libration 22b. Method of Disposition 1 Burlel 23a. Part I. Entar tha disaasa, or complications that caused tha daeth. Do not enter the shock, or heart failure. List only ona cause on each line. 1 Cardiac Arrhythmia Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 1 Due to (or es e consequent in the cause of the middle) 2 Due to (or es e consequent in the cause of the middle) 2 Due to (or es e consequent in the cause of the middle) 2 Due to (or es e consequent in the cause of the middle) 2 Due to (or es e consequent in the cause of the middle) 3 Due to (or es e consequent in the cause of the middle) 4 Docadent Ever in U.S. 1 Decedent E	1. Decedent'e Name (First, Middle, Last) 48. Facility Neme (If not institution, give street and number) 5. Social Security Number 6. Sex 1 M 2 M 7. Age (In frs. lest birthday) 10 Months Deyt 10 Months	4a. Facility Neme (It not institution, give street end number) 4b. City, Town, or 1 4c. Sex	1. Decodent's Name (First, Middle, Last) 4a Facility Name (If not institution, give street ean number) 4a Facility Name (If not institution, give street ean number) 4b Sylvan 4c Facility Name (If not institution, give street ean number) 4c Sylvan 4c Facility Name (If not institution, give street ean number) 4c Sylvan 4c Facility Name (If not institution, give street ean number) 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Facility Name (If not institution, give street ean number) 5c Social Security Number 4c Sylvan	1. Decodern's Nampe (First, Middle, Last) 4.6 Facility Name (If not institution, give street end number) 4.6 Facility Name (If not institution, give street end number) 4.6 Solid Security Number 5. Social Security Number 6. Sax 7. Age (In first, lest birmday) 10. Clay, Town or Location of Decident 10. County 10. Steel 10. County 10. Steel 10. County 10. Clay, Town or Location 10. Steel 10. County 10. Steel 10. Steel 10. County 10. Steel 10. County 10. Steel 10. County 10. Steel 10. Steel 10. County 11. Martial Status 12. Was Decedent Ever in U.S. 11. Was Decedent Ever in U.S. 11. Was Specify Clay, Married 11. Steel Steel 11. Steel Steel Steel County 11. Steel Steel 11. Steel Steel Steel County 12. Was Decedent Ever in U.S. 13. Was Decedent Steel County 14. Recet 15. Deceder's Steel Steel County 16. Steel Steel Steel County 17. Fashar's Name (First, Middle, Last) 18. Deceder's Usual Occupation 18. Mother's Name (First, Middle, Malden Suman 19. In Informatis Name/Relationship (Type, Print) Mother's Name 19. Informatis Name/Relationship (Type, Print) Mother's Name 19. Informatis Name/Relationship (Type, Print) Mother's Name 19. Informatis Name/Relationship (Type, Print) Mother's Name (First, Middle, Malden Suman 19. Mother's Nam			

State Registrar

Bert F. Morton, M.D., 31. Dete filed (Month, Day, Year) SAN 27 1999

Agnes HealthCare, 900 S Caton Ave., Baltimore, Md. 21229



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1830 MUAYAD ALDAGHSTANI JANUARY 08 4c. County of Deeth 4e Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth BOWIE PRINCE GEORGES CENTIER BOWIE HEALTH If Undar 24 Hrs. 8. Dete of Birth
(Month, Day, Year) 9. Birthplaca (State or Foreign Country)
IRAQ If Under 1 Yaar 5. Social Sacurity Number 6 Sex 7. Age (In yrs. lest birthdey) Deys Hours Months 1X M 2 □ F 64 453-64-5963 Usual Residence of Decadent 10e Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Prince George Bowie 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 16010 Excalibur Rd, #A - 307USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. Bleck. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas: 1 Naver Married 2 Married 1 ☐ Yes 2 1 No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced 16e. Decadent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Printing Printer 17. Fathar's Nema (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) Unknown Unknown 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) 6166 Leesburg Pike, Falls Church, Va. 22044 Basil Aldaghstani-Son 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Suitland, Md. ashington Nat Cemet. 1/12/99 of Funerel Service Licensee 22. Name end Address of Fecility UNIVERSAL MORTUARY INC. 411 Kennedy St, N.W., Washington, D.C. 23a. Pert1. Enter the disaesa, or complications that cause the deeth. Do not entar the moda of dying, such es cardiac or respiretory arrast, shock, or haart failura. List only one causa on aach in the cause of the Approximata Intarval Batwaan Onsat end Daath Immediata Cause (Final ARTERIOSCUEROTIC CARDIOVASCULAR OSEASE diseese or condition resulting in deeth) Due to (or es e consequance of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in deeth) Last Due to (or es e consequenca of) Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23b. Did tobacco use contributa to the ceuse of death? 1 Yes 2 No 3 Probably WUnknown 24b. Were eutopsy findings eveilable prior to 24a. Wes an eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show soical Example: must be notified at

Directo

Funeral

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Pages 1 and 2 should I

permit. Pages 1 and 2 sh Department of Health end Important: If Item 27 is m any Injury or other traum page.

Hygiene.

7 is marked other traumatic event, I

Baltimore, Maryland 21215-0020

Examiner physician and s the bunal-trans Physician/Medical aftending for use as signed by the a by should Completed ils certificate has b director, page 2 s Be To

The law requires that the deeth certificate be executed Hospital or Attending Physician: 24 hours after death. this funeral After Director: To the Hospital or within 24 hours aft To the Funeral DI complataly filled in

P.O. Box 68760.

Division of Vital Records,

Certification:

Medical

State Registrar 25. Was casa raferrad to medical ninar 1X Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Yeer) 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred Injury et Work? 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicida 29a Certifies 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and dua to the ceuse(s) end manner es steted.

25 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menger stetal. 29d, Dete signed (Month, Dav. Year) 29c. Licansa number

29b. Signat@re

ne and eddress of person who complate MARIO F. GOLLE

23a) (Type, Print)

ITAL DRIVE, CHEVERLY, MARYL

31. Deta filed (Month, Day, Year)

JAN 1 1999

32. Registrar's Signatura

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	State of Maryland / Department of Health and Mental Hygiene	9 0	9	3

			tato or maryian		tificate of		Re	g. No.		
		1. Decedent's Name (First, Middle, Last)					2. Dete of Death Month	Day Yes	3. Time of Death	
	Physician /Medical	Marie Bittner Am	mon				January			
	Examiner	4a Facility Name (If not institution, give street			4b. City, Town, or Location of Deeth 4c. County of Death					
	Examine	Magnolia Center		Lanham	Prince George's					
	Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.	lest birthdey)	If Under 1 Year	If Under 24 Hrs.				
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	urs after deeth with the Marylen et., or items 23s or 28s-4 show Examiner must be notified at by Funeral Director	10e. Street end Number		1016	10f. Zip Code		10	a. Citizen of What	Country?	
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	riter deeth v riter must riter must	6924 Tierra Verde	STREET Was Decedent Ever in U.	C 13 L		1668	ecify Yes or No.		merican Indien	
	the training	11, maritar olares	Armed Forces?	10.1	f Yes, specify Cub	Hispenic Orlgin? (Speen, Mexican, Puerto	Rican, etc.)			
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121215-0020		15. Decedent's Education		16a Dagge	dent's Usual Occup	nation	1			
	ed within 72 ho ygiene. or than "natur. rt, tra we call Completed	(Specify only highest grade co	mpleted)	(Give	kind of work done	during most of work d)	ing	9. Birthplece (Stete or Foreign Country) 1910 Germany 10d. Inside City Limits 1 XYes 2 No 1. Citizen of What Country? U.S.A. 14. Rece - American Indien, Bleck, White, etc. Specify: White th. Kind of Business/Industry Own Home tiden Sumeme) City or Town, State, Zip Code) y land 20706 to Location - City or Town, State Alexandria, Virginia Esville, MD 20781 Approximate Interval Between Onset and Death		
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0	Pages nent of It	1 ☐ Burial 2 🖾 Cremation 3 ☐ Remo		emetery, cren	natory or other ple	ice)	Date	oo. Location - Oily	or rown, state	
iii	men ment: jury	4 ☐ Donetion 5 ☐ Other (Specify)	Μe	-		matory 1	-12-99	Alexand	ria, Virginia	
Baltimore,	permit. Pages 1 end Department of Health Important: if Item 27 eny Injury or other ti once.	21. Signeture of Funeral Service Licensee			. Name and Addre		n 4			
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ita	s certificate has b director, page 2 s	25. Was case referred to medicel examiner?				26 Place of Deal	th (Check only one)		
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0	o Pt		8a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo	ry et ork?	28d. Describe ho	w injury occurred		
0	ath. atic	Netural 5 Pending 2 Accident Investigation	(, 23)	,,		Yes 2□No				
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	sphi hour hera y fille		n: To the best of my kno							
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director Attent his certific completely filled in by the funeral director, Medical Certification: To Be ((Check only 2 Madical Examiner: one)	On the basis of exemina and manner stated.	ition and/or in	vestigation, in my	opinion, deeth occur	red at the time, de	te and place, and	que to the cause(s)	
	Vithin Vithin Somp	29b. Signature and title of certifier			29c. Licen	se number	29	d. Data signed (M	onth, Day, Year)	
		por (Up			0/	3337		1/11/89	/	
	100	30. Name and address of person who compl	lated cause of death (ter-	n 23e) (Time	Print)	- ~	7	1 /		
	(12)	T / HAN / / L ZX	DAY	1	mh'ha	he it.	Dovu	In the	· 8604.	
	Charles	31. Date filed (Month, Dey, Year)	Registrar's Signa	ature	,	1-			0	
	State Registrar	IAN 1 2 1999	Lema	6	1					

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WIEZI	ACHOLONU	State of Maryland / Department of Health and Mental Hygiene 9 9 0 9	3
		Cartificate of Dooth	

	ODOWUJEZI ACHOLONU State of Maryland / Department of Health and Certificate of Death 1. Decedent's Name (First, Middle, Last)						Reg. No. 2. Date of Death 3. Time of Death			
Physician	ODOWUEZI ACHOLONU					JANUAR	Day	Year 999	2053	
/Medical Examiner						Location of Death				
	1126 APPLE VALLEY RD. ACCOR									
Funeral Director	212 0 1 1003	X 7. Age (In yrs. last birthday) If Under 1 Y Yrs. 28 Yrs. If Under 1 Y Montha D			Hours Min				e (State or Foreign YORK	
natural; or items 23a or 28a-1 show diesi Examinet.must be notified at eted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location							t0d.	Inside City Limits	
to to										
r 28a	10e. Street and Number 10f. Zip Code					10g. Citizen of What Country?			?	
23a c	5403_67th_Avenue			20737			USA			
'natural', or teme 23a or 28a+'ehow edical Examinat must be nothred at leted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			 Was Decedent of Hispanic Origin? (Specify Yes or It Yes, apecify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2 ∑ No Specify: 			14. Race - American Indian, Black, White, etc. Specify: BLACK			
r, to Medical Exac Completed by	15. Decedent's Edu	ication	16a. Decede	ent's Usual Occup	pation during most of wo	orkina	16b. Kind of Bu	siness/Indus	try	
the Medical	Elementary/Secondary (0-12) College (1-4or 5+)				d)					
F O	12th 17. Father's Name (First, Middle, Last)					PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame)				
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To						r Rural Route Number, City or Town, State, Zip Code)				
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or other traumatic event,	20a. Method of Disposition	cometent cremator			ce)	Date 20c. Location - City or Town, State			, State	
lury o	1 Deurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glenwood Cemetery					1-13-99 Washington DC				
any injury or	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746									
physician and s the burial-trensit	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last	bDue to (or	r as a consequence as a	ence of):	201402			E C C C C C C C C C C C C C C C C C C C		
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rector, page 2	MARKET TO SECURIT					16	ves 2□No	NEW	′es 2□ No	
Be	25. Was case referred to medical examiner?	26. Place of Deeth (Check only one)								
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fons	27. Manner of Death 1 Netural 5 Pending investigation	28a. Date of Injury (Month, Day Year) COUM) 1-3-99 1528 M 28c. Injury at Work? 1 22 M 1 22 M				SWOJET WAS SHOT.				
by the	3 Suicide 6 Could not be	28e. Place of Injury - At home, tarm, street, tactory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
E 2	4 ☑ Homicide	tours IV wooder Shops				1126 DPPLE VALLY ROPAING GEDRIG				
Medical Cert	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. Check only one)									
Medical C	29b. Signature and title of certifier O.C.M.E.					l.	29d. Date signed (Month, Day, Year) JANUARY 04, 1.999			
State	30. Name and address of parson who co	1 /	11 Penr		, Baltim	ore, Mar	yland 21	201		

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Registrar

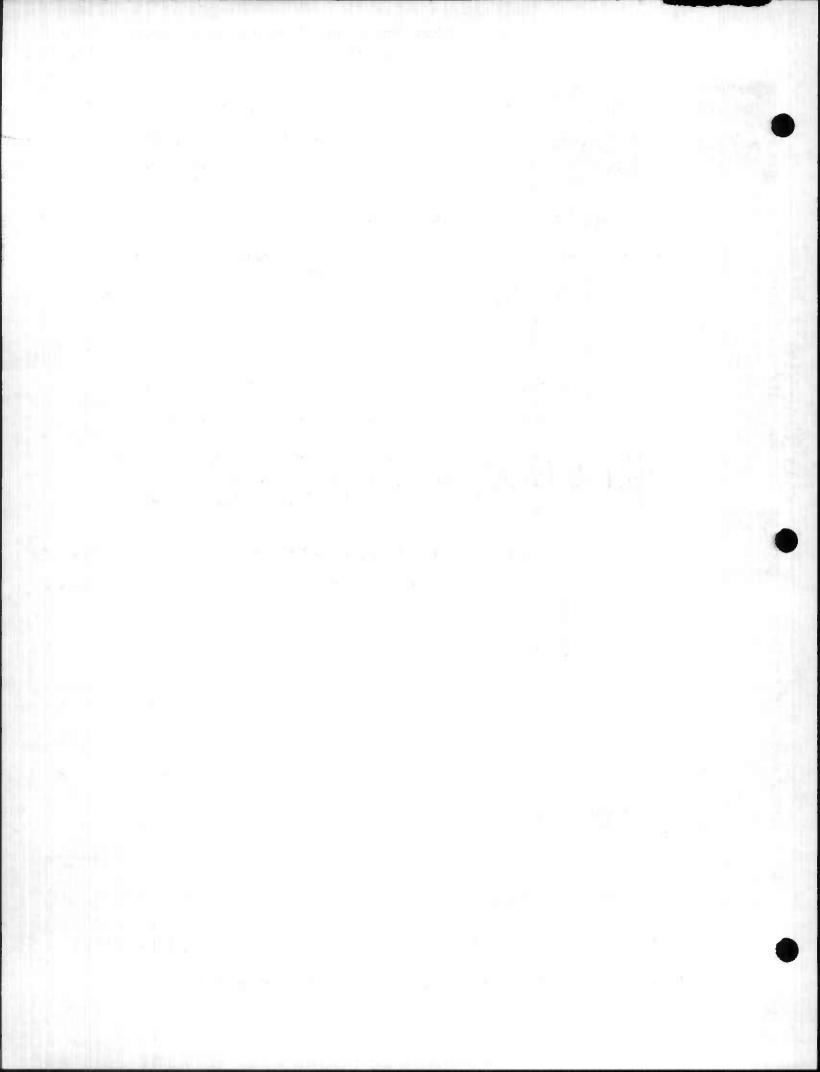
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Ce	rtificate o	f Death		Reg. No.		
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Physician /Medical	ı	John Robert	Boswell, Sr.				JANUARY	10 1999	Yeer 9	4:05pm
Examiner	1	a. Facility Neme (if not institution,	rive street and number)			4b. City, Town, o	or Location of Deet	4c. County	of Deeth	
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uneral irector		218-05-9893	XXM 2□ F 7. Age (In)	yrs. last birthdey, Yrs.	Months De		n. (Month, Da	b, Year)	Cour	olece (Stete or Foreign otry) land
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28a-f show	N	Maryland Charle			Plains					1 ☐ Yes 2 ☒ No
be notfled Director	ŀ	Oe. Street and Number		WITTEE	10f. Zip Code	•		10g. Citizen of	What Cour	ntrv?
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by	•	1 Never Married 2 Married 3 Widowed 4 Divorcad	Armed Forces? 1 XYes 2 No If Yes, Give Yeer or Dates: WW]		If Yes, specify C		erto Ricen, etc.)	Specif	ck, White, y: Wh	ite
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		ICHAEL A. PIMEN'				D WALDORF	MADVIAN	0 20602		
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State of Mar	yland / Department	of Health and	Mental	Hygiene
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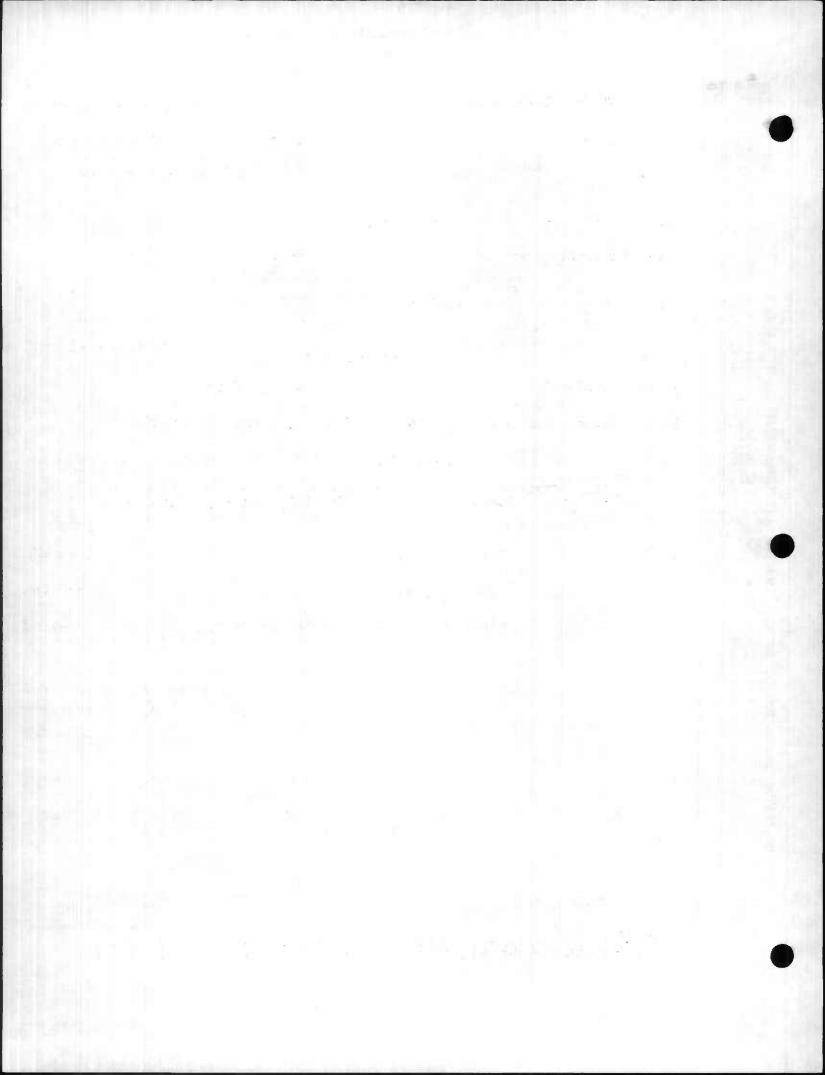
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Vaer **Physician** ARNOLD GRAVES BEDINGFIELD JANUARY 13, 1999 11:30 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. Cify, Town, or Location of Death 4c. County of Death Examiner Manor Care Largo Prince George's If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) If Under 1 Year 5. Social Security Number Birthpiece (Stete or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1X M 2 F Days 579-32-9112 82 Oct. 1, Director 1916 Alabama Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b County 10c. City. Town or Location 7 is marked other than "naturel", or itema 23a or 28a-f show treumatic event, the Madical Examiner must be notified at 1 ☐ Yes X No Director Maryland Charles Bryantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7064 Old Leonardtown Road 20617 USA Funeral 72 hours after death 12. Was Decedent Ever In U.S. Armed Forces? 1 XI Yas 2 □ No 1f Yes, Give Year or Dates: 1944-46 14. Raca - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Bieck, White, etc. 1 Nevar Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 7 Hygiana. d 2 should be filed within 7 th and Mental Hygiana.
7 Is marked other than ** Elementary/Secondary (0-12) College (1-4or 5+) Internal Rev. Serv. Treasury Agent 18. Mother's Name (First, Middle, Melden Sumeme) 17. Fether's Name (First, Middle, Last) Jesse M. Bedingfield Juanita Oliver 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 st Department of Health and Important: if item 27 is m any injury or other treum 5537 Huckleberry, Bryantown, MD 20617 Joan B. Crown - Daughter 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 Cremation 3 Ramoval from State Maryland Veterans' Cem. 4 ☐ Donetion 5 ☐ Other (Specify) 1-21-99 Cheltenham, MD 21. Signature of Foneral Service Licensea 22. Name and Address of Facility
Huntt Funeral Home, Inc. John P. Knisley M01464 P. O. Box 156, Waldorf, MD 20604-0156 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset end Deeth **Physician** /Medical Immadiate Ceuse (Final disease or condition resulting in death) Examiner Examiner ettending physician end for use as the burial-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Pankin Son Box 68760. Physician/Medical 23b. Did tobacco use contribute to the cause of death? P.O. ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 21 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, by requires 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy Completed peen The law page 2 has 2 0 No this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physician: director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) To Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of Certification: After ours after dean Attending 1 Neturei 5 Pending 1 TYes 2 No investigation 2 Accident 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral C Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es stated.

2 Medical Examinar: On the best of exemination and/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s) end menner stated. 29e. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier Ka KUSI 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar 31. Date filed (Month, Dey, Yeer) **JAN 15**



Bowie, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item #3. Per Phys. PCC 1-21-9 State of Maryland / Department of Health and Mental Hygiene 99 Amend item #20b.Per FH PGC 1-11-99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 3:30 1:30p. Rudolph Butts /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Hospital Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) 100 M 20 F Months Yrs. Director 579-28-8101 70 July 3,1928 Wash., D.C. Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location ms 23a or 28a-f show 10d. Inside City Limits 1X Yes 2 □ No Director Prince Georges Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10000 Derrick Place Funeral 20735 United States 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes ≥ 2 ☒ No If Yes, Give Year or Dates: r than "natural", or items the Medical Examiner my Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married 21215-0020 Specify: Black 1 ☐ Yes 2 ☒ No Specify: by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation

Size kind of work done during most of working Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry (Give kind of work done du life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Government U.S. Postal Service nd 2 should be filed slith and Mental Hygie 27 is marked other of traumatic event, is Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 John A. Butts Bertha Triplett 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: if Item 27 is any Injury or other trau once. 10000 Derrick Place Clinton, Maryland 20735 Barbara W. Butts/wife Baltimore, 20b. Placa of Disposition (Name of complex), cremptory, cremptory or other place)

Maryland National Memorial Park

Wash.

Date

20c. Location - City or Town, State

2nd. Laurel, Maryland 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Servica Licensee 22. Name and Address of Facility Hodges and Edwards F.H. 23a Fart. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finat Athero Sclerotic Cardio Vascular Distare disease or condition resulting in death) **Examiner** pertensio The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and bunial-tran Box 68760. Physician/Medicai Due to (or as a consequence of): P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 3 No 3 □ Probably 4 □ Unknown director, page 2 should be det Records, Py 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 26 ER/Outpatient 3□ DOA 1 Yes Certification: To After this within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division Attending 5 Pending Investigation 1 ZiNetural 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 6 To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

AKESH ARORA, MD 14300 GALCANT FOX LNBOWIE MD 20715 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

1 1 1999 x

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 9 6

			Ce	rtificate	of Death		Reg. No.		
D1	1. Decedent's Name (First, Middle,	Last)	Marie y			2. Date of D	eath Day	Yeer	3. Time of Death
Physician /Medical	LONDON	IMANI	BATTS			Januar			8:20 PM
Examiner	4e Facility Name (If not institution, 11823 Sylvia D				4b. City, Town	n, or Location of Dea		of Death ce Geo	orges
Funeral Director	5. Social Security Number 215-47-2590	Sex 7. Age (In	yrs. last birthday) 2 Yrs.	If Under 1 Months	Year If Under 24 Days Hours	Min. (Month, L			ace (State or Foreigny) Ington DC
,	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10	d, Inside City Limits
S de la				жаноп				10	1 □XYes 2 □ No
oct of	7	Georges C.	linton	100 70 0	4.		10- 04	45-4-0	
r items 23s or 28s-1 showning must be notified at Funeral Director	10e. Street and Number 11823 Sylvia Dr	ive		10f. Zip Co	20735		U.S.A		ryr
by by	11. Maritel Status **Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 22 No If Yes, Give Yeer or Deles:		Was Deceder If Yes, specify		n? (Specify Yes or N Puerto Rican, etc.)	Bled	e - America ck, White, e Black	tc.
edical	15. Decedent's		16a. Dece	deni's Usual C	Occupation	of warding	16b. Kind of B	usiness/Ind	ustry
sumetic event, the Modest To Be Completed	(Specify only highest Elementary/Secondary (0-12) N/A	College (1-4or 5+)		DO NOT use	done during most o retired)	or working	N/A		
Be C	17. Father's Name (First, Middle, La	ist)			18. Mother	s Name (First, Middi	le, Meiden Sumen	10)	=1.30/11
0 0	Dexter C. Batts				Linds	a J. John	eon		
traumatic	19e. Informent's Name/Reletionship	(Type. Print)	19b. Meili	na Address /S		or Rural Route Num		State. Zip	Code)
	Dexter C. Batts					Clinton,			
other tr	20a. Method of Disposition	- Facilei	b Place of Dispe	sition /Name	of	Date	20c. Location		wn, State
eny injury or o	1 XBurial 2 ☐ Cremation 3		cemetery, cre						
ler)	4 Donation 5 Other (Spe		Forest F			1-9-99	Clinton	, Mary	yLand
ny in	21. Signeture of Funeral Service Li	censee	2		Address of Facility	eral Home	. Inc.		
	7. P. n	Inshall		4217 9	th Stree	t N.W. Wa	shington	, DC	20011
	23a. Part. Enter the disease, or constant, or heart failure. List or	omplications that ceused the	death. Do not en	er the mode	of dying, such as o	erdiac or respiratory	arrest,		Approximate Interval Between
ician		ny one case on cash me.							Onsel and Death
dical	Immediate Cause (Finel disease or condition	RESPIR	nThey	ARRE	57				
niner	resulting In deeth)	d	to (or es a conse						
je l					4				
ial-transit Examiner	Conventially list conditions	D	to (or as a conse		ATTOPI	7 9			
s the burial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	500	10 (0) 43 4 00/130	querice ory.					
cai ou	Cause (Disease or Injury that initiated events	C. Due 6	to (or as a consec	monco of).				-	
* E	resulting in death) Last	■ d.	to (or as a conser	quence or).					
etached for usa	Part II. Other eignificant condition	s contributing to death but not	resulting in the u	ınderlying ceu	se given in Part I.	23b. DI	d tobacco use co	ntribute to	the cause of death
igned by the be detach be detach by Phy.						10	2 Yee 2 10	3 Prob	ably 4 Unknow
page 2 should be d						24a. Wa	as an autopsy formed?	eva	ore autopsy findings allable prior to appletion of cause death?
Page						10	Yes 25No	10	Yes 2 No
	25. Wes case referred to medical				në Diese				200
S E	examiner?	Hospital:	- C = D (0)		Other	of Death (Check only		(016	a
_ F	27. Manner of Deeth		2 ER/Outpatie		4 LI Nurs	sing Home 5 Re	e how injury occur		′)
fune Ion	1 Natural 5 ☐ Pending	28e. Dete of Injury (Month, Day Yea	(r) Injury	М	Injury at Work? 1 ☐ Yes 2 ☐ N				
al Director: After to led in by the funeral Certification:	3 Suicide 6 Could no		At home form et				(Street and Numi	her or Rure	l Route Number
d in by	4 ☐ Homicide determin	28e. Place of Injury - building, etc. (Sp	pecify)	reet, ractory, c	ince	City or 7	own, Stete)	00 00 11010	THOUSE THOMBON,
<u>a</u>	(Check only 2 Medical Ex	Phyeiclan: To the best of my saminer: On the basis of exar							
completely Medica	one)	and manner stated.							
000	29b. Signeture and title of certifier				icense number		29d. Date signe	u (wonth, l	vay, 168/)
\Box	David R	- Nax	から		D299	48	1/	11/9	9
1)	30. Name end eddress of person w	no completed cause of deeth	(Item 23a) (Type	Print)					-
/	DAVID R. NA	WE min v	pist n ?	GRADA	VENTE	C/O CNA	r 111	mich	CON to
Charles		32. Registrar's S	Signature	4		10 01011	1		W. DC
State Registrar	31. Date filed (Month, Day, Year) JAN 1 4 1999	Bengin	B. 1	land.	1			10	

1. Decedent's Name (First, Middle, Last)			Certificate of	Death	2. Date of Dea	eg. No.		3. Time of Dea
MAZZTE		BROWN			Month	Dey	Year	1:20 PM
4a. Fecility Neme (If not institution, give s	etraat and number	DICOUL		4b. City. Town, or Lo	January	9, 1999 4c. County	of Dogsto	
Holy Cross Hospita			h.,,,,,,	Silver Spi		Mont		ry
5. Social Security Number 6. Sex 5.78−58−56.75	M 2√2 F	yrs. last birtho	Months Dev		8. Date of Birth (Month, Day	Year)	Cou	.,
Usual Residence of Decedent		91			June I,	_1907_N	orth	Carolin
10a. State 10b. County	100	c. City, Town o	or Location					10d. Inside City Lir
D.C. N/A		Washin	gton					Yes 2
10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Cou	ntry?
401 K Street N.W.	, #719W		2000)1		U.S.A	. •	
11. Maritel Stetus	12. Was Decedent Ever Armed Forces?	In U,S.	13. Wes Decedent of	Hispanic Origin? (Spetban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- Americk, White,	can Indian,
1 Never Married 2 Married	1 ☐ Yes 24 No If Yes, Give		1 ☐ Yes 2 N		ritouri, oto.,	Specify:	Blac	k
3 XWidowed 4 ☐ Divorced	Yeer or Dates:		12 100 2211			эреспу.		
15. Decedent's Educ (Specify only highest grade		(0	ecedent's Usual Occ Give kind of work don	e during most of work	ing	16b. Kind of Bu	siness/In	dustry
Elementery/Secondary (0-12)	College (1-4or 5+)	11	He. DO NOT use reti Practical	red)		Hospita	1	
8th			riactical					
17. Fether's Name (First, Middle, Last) George Rainey				18. Mother's Name		vialuen sumami	9/	
								17-11-1-1
19a. Informant's Name/Reletionship (Type				et and Number or Run				
Shirley Brown - Da			Emanue 1	Court N.W.				
20a. Method of Disposition 1 ☑XBuriel 2 ☑ Cremation 3 ☑Re	emoval from State	cemetery,	crematory or other p			20c. Location		
4 ☐ Donation 5 ☐ Other (Specify)	1	Manley	Cemetery				Rap	ids, N.C
21. Signature of Funeral Service License	∌e		22 Marshar	ress of Facility Funera	1 Home,	Inc.		
A. T. man	Lell			h Street N			, DC	20011
23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the	death. Do not	t enter the mode of d	ying, such as cerdiac	or respiratory arr	est,		Approximate Intervel Between
	1						Į.	Onset and Deal
Immediate Cause (Final disease or condition	1200	exex	els.					6 low
resulting in death) a			nsequence of):				1	
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Sequentially list conditions,	Due	to (or as a co	nsequence of):				1	
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury							1	
thet initieted events resulting In death) Last	Due	to (or es a cor	nsequence of):				1	
	1							
	•						I	
	0		0 1 -	given In Part I.	23b. Did to	obacco use con	tribute t	o the cause of d
	A.	toral	1 Pilon	Vara'	1 □ Y	es 2 No	3□ Pro	bably 4 Unk
	40 CKES		1000	CHY			9.4h 14	loro autono: fin d
	ro extex	u, e.	ville	ay	040 1440	n outcom	£40. W	ere autopsy findi vailable prior to
	ro extex		N-CELE	ay	24a. Was a perfor		CC	impletion of cause
Pert II. Other significant conditions con Cliffely Sarl Revere le	enerter		N-Cele				CC	empletion of causideath?
	enestea	-1	V-000	ciy		med?	of	impletion of cause
acues de servered to medical examiner?				26, Place of Death	perfor	med? es 2□No	of	ompletion of causi death?
25. Was case referred to medical examine? 1 Yes 2 No H	lospital:	2 ER/Outp	atient 3□ DOA C	her: 4 ☐ Nursing Ho	perform 1 □ You h (Check only or	es 2 No	of of	ompletion of causideath?
25. Was case referred to medical examiner? 1 Yes 2 H	Inenital:	2 ER/Outp	atient 3 DOA Conne of 28c. fn	Other: 4 Nursing Ho iury at ork?	perform	es 2 No	of of	ompletion of cause death?
25. Was case referred to medical examiner? 1	lospital: 1 Lampatient 28a. Date of Injury (Month, Day Yea	2 ☐ ER/Outp. 28b. Tin Inju	atient 3 DOA Cone of 28c. fn W	Other: 4 Nursing Ho jury at lork? Yes 2 No	performula 1 You have the Check only or me 5 Residue 28d. Describe have	es 2 No	of of	mpletion of cause death? □ Yes 2□ No
25. Was case referred to medical examiner? 1 Yes 2 No H	lospital: 1 Limpatient	2 ☐ ER/Outp. 28b. Tin Inju	atient 3 DOA Cone of 28c. fn W	Other: 4 Nursing Ho jury at lork? Yes 2 No	performula 1 You have the Check only or me 5 Residue 28d. Describe have	es 2 No	of of	ompletion of cause death?
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25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Phys	lospital: 1 Impatient 28a. Date of Injury (Month, Day Yea 28e. Plece of Injury - building, etc. (S)	2 ER/Outp ar) 28b. Tin Inju At home, farm pecify)	atient 3 DOA ne of 28c. fn ury M 11 n, street, factory, office death occurred et the or Investigation, In my	Other: 4 Nursing Ho uny at ork? Yes 2 No e time, date end plece, r opinion, death occurr	performence of the control of the co	es 2 No ence 6 Other ow Injury occurr treet and Number ause(s) end me ate and place, a	or (Special of Parameter of Par	mpletion of cause death? □ Yes 2□ No fy) al Route Number, steted. o the cause(s)
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25. Was case referred to medical examiner? 1 Yes 2 Medical 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physical Conditions 29b. Certifier (Check only one) 1 Certifying Physical Conditions 20b. Certifier (Check only one) 1 Certifying Physical Conditions 20b. Certifier (Check only one) 1 Certifying Physical Conditions 20b. Certifier (Check only one) 1 Certifying Physical Check only one)	28a. Plece of Injury 28a. Plece of Injury building, etc. (S)	2 ER/Outp ar) 28b. Tin Inju At home, farm pecify) y knowledge, c	atient 3 DOA Come of Jack In	Other: 4 Nursing Ho uny at ork? Yes 2 No e time, date end plece, r opinion, death occurr	perform 1 Ye 1 Ye 1 Check only or The Signature of Residue 28d. Describe his 28f. Location (Signature of Town 28f. Location (Signature	es 2 No ne) ence 6 Othe ow Injury occurr treet and Number n, Stete) ause(s) end me ate and place, a	of o	mpletion of cause death? □ Yes 2□ No fy) al Route Number, steted. o the cause(s) Dey, Year)

State Registrar

Physic /Med Exam

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be sotified at

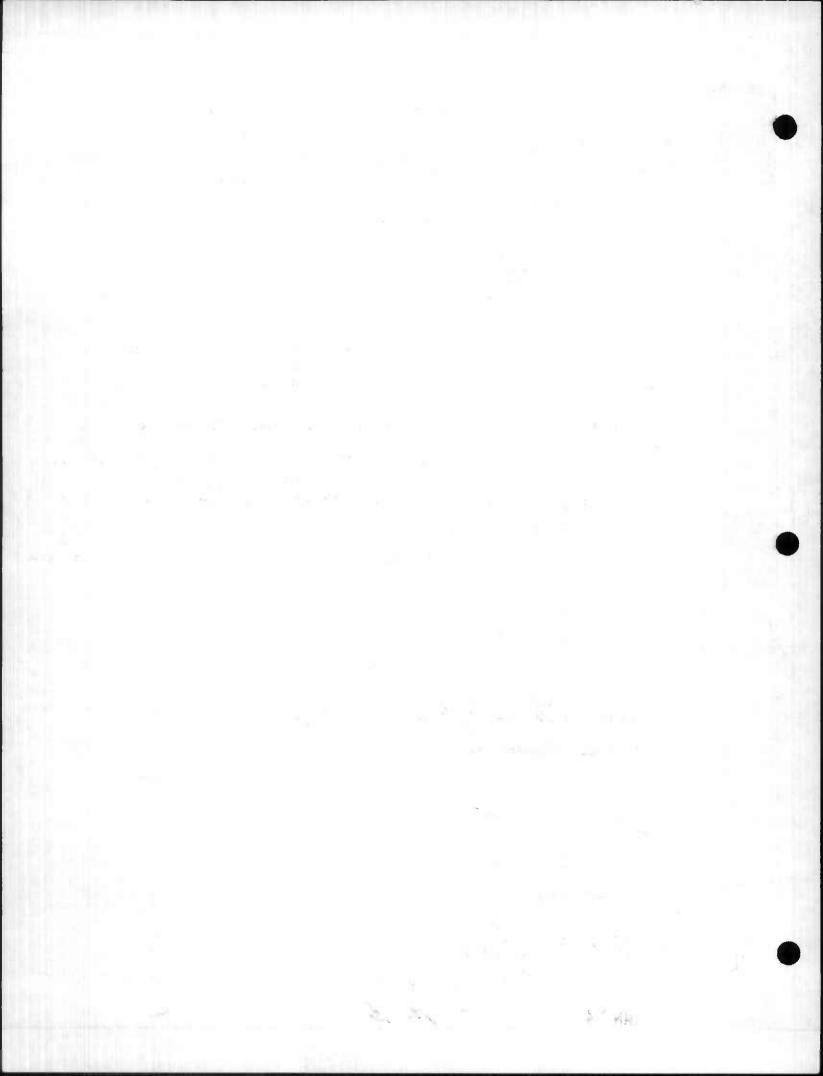
Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		Certificate of Death	Reg. No.	
Physician	Decedant's Nama (First, Middla, Last) DAVID BAILEY			Yaar 3. Tima of Deati
/Medical				999 6:301
Examiner	a. Facility Nama (If not institution, give street and number) 8110 MARTIN LUTHER KING	4b. City, Town, or	1	
	Social Sacurity Number 6. Sax 7. Aga (In yrs. last bi			Georges
Funeral Director	237-82-48/77 1XM 20F 50	Yrs. Months Days Hours Min.	(Month, Day, Year)	9. Birthplaca (State or Fore Country)
nector	sual Rasidanca of Dacadant		MAY 13, 1948	WASHINGTON,
show dat		vn or Location		10d. insida City Lin
notified at	MD Prince Georges GI	enorden		1 □ Yas 2 🔀
or 28a-f s be notified Director	De. Street and Numbar	10f. Zlp Coda	10g. Citizan of Wi	hat Country?
3a or	8110 MARTIN LUTHER KING HW	x 20706	U,S	.A.
r flores 23a officer must	Marital Status 12. Was Dacedant Evar in U.S.	13. Was Decedant of Hispanic Origin? (S If Yas, specify Cuban, Maxican, Puan	pecify Yas or No- 14. Race	- Amarican Indian,
F. F.	Armed Forcas? 1 □ Navar Married 2 ☑ Marriad 1 □ Yas 2 ☑ No		o Hican, atc.) Black	, Whita, atc.
D 2	3 ☐ Widowed 4 ☐ Divorced If Yas, Giva Yaar or Datas:	1 ☐ Yas 2 ☐ No Spacify:	Specify:	BLACK
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important: any injury once.	Signature of Eureral Service Liconsee	22. Nama and Addrass of Facility		
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page 2 should	Multiple proportion -		performed?	available prior to completion of cause of death?
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State of Maryland / Department of Health and Mental Hygiene

ITEM: #1 PER PHY G769 3-31-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death OTIS FRANCES BRENT 3. Time of Death Month **Physician** RANCES 650AM 0 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Brighton Manor Nursing Home Baltimore Baltimore if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day,) 8/19/21 9. Birthplace (State or Foreign Country)
Wash., D.C. **Funeral** 1 □ M 2X F Months Days Hours Min 577-26-8916 77 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location Show 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, tra Maucal Examiner must be notified at Md Prince George's Cedar Hgts. Director Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6214 Kolb St. Funerai 20743 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 end 2 should be filed within 72 hours after Never Married 2 Married ☐ Yes 2\(\)\(\)\(\)\(\)\(\)\(\) 21215-0020 Specify: Black 1 Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) 10th Waitress Restaurant Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Heelth and Mental Hy Important: If New 27 1s marked oth any injury or other traumatic event once. Be Benjamin Brent 20 Annie Colston 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Jones/Daughter 112 Staton Dr., Upper Marlboro, Md. 20774 Baltimore, 20b. Place of Disposition (Name of 20a, Method of Disposition Dete 20c. Location - City or Town, State cemetery, cremetory or other place)
Harmony Mem. Park 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/14/99 Landover . Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility
H.S. Washington & Sons Co., Inc. 21. Signature of Funeral Service Licensee reall. any W. 4925 Burroughs Ave., N.E., Wash., D.C. 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate nterval Bety Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last attending physician and for usa as tha burial-fran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of): been signed by the s should be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 Yes 2 No Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? pege 2 should Completed 24e. Wes an autopsy performed? 1 Yes 2 No certificate or Attending Physician: Ber 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) 10 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this the funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? **←** Naturat 5 Pending Investigation daath. 1 Yes 2 No To the Hospital or Attendition within 24 hours efter death.

To the Funeral Director: A completely filled in by the formal completely filled in the formal 2 Accident 6 Could not be 3 ☐ Sulcide 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 4 | Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

LIAOAT ACI 82 | N EUTA EUTAW Street Baltimire MD 2/201 31. Date filed (Month, Day, Year)

JAN 1 2 1999 32. Registrar's Signature State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

the Maryland Show r than "natural", or hame 23s or 28s-f ahor the Medical Examiner must be notified at 72 hours after Baitimore, Maryland 21215-0020

P.O. P

of Vital

MARLON DION BURFORD 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** JANUARY 06 1999 2324 P Dion Burford Marlon /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Deeth Examiner 7000 ACCOKEEK BRANDYWINE PRINCE RD. GEORGES CO 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) B. Data of Birth (Month, Day, Year) **Funeral** 1₩ 2□ F Months Days Hours 22 Yrs. 218-17-6970 Director October 22,1976 Washington, D.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 No Director Maryland Prince Georges Clinton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11509 Glissade Drive 20735 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, While, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Haalth and Mentel Hyglans. Important: If frem 27 is marked other than "nearly injury or other traumatic event, the Bad onds. mentary/Secondary (0-12) College (1-4or 5+) 12th grade Fork Lift Driver Home Depot Warehouse 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Burford Peggy Jean Rucker James Hugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) James & Peggy J. Burford (Parents) 11509 Glissade Drive, Clinton, Maryland 20735 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery/Jan.12,1999/Clinton, Maryland 22. Nama and Addrass of Facility Robert G. Mason Funeral Home, Inc. 21. Signature of Educated Service Licenses 1661 Good Hope Road, S.E.; Washington, D.C. 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** Immediata Cause (Final diseasa or condition resulting in death) /Medical questet Words of A Examiner Examine certificate be executed physicien end is the burial-trans Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or es a consequence of): 80 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wera eutopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 □ No Yas 2□ No 8 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa XXYes 2 No 10 5 ☐ Residence 6 When (Specify) SCENE 1 ☐ Inpatient 2 ☐ ER/Outpalient 3 ☐ DOA edical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert Division Attending 5 Pending invastigation 1 Natural Injury death. 2 No Shal Found 46/99 1 Yas 2310 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7000 A CCKLAK Road 3 Suicide 6 Could not be Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) after 4 Homicide 8 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. To the Hospital o within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 29d. Data signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number JANUARY 07, 1999 O.C.M.E ting 30. Name and address of person who completed cause whath (Item 23a) (Type, Print) THEODORE MIKIT 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year)
JAN 1 2 1999 32. Registrar's Signatura State

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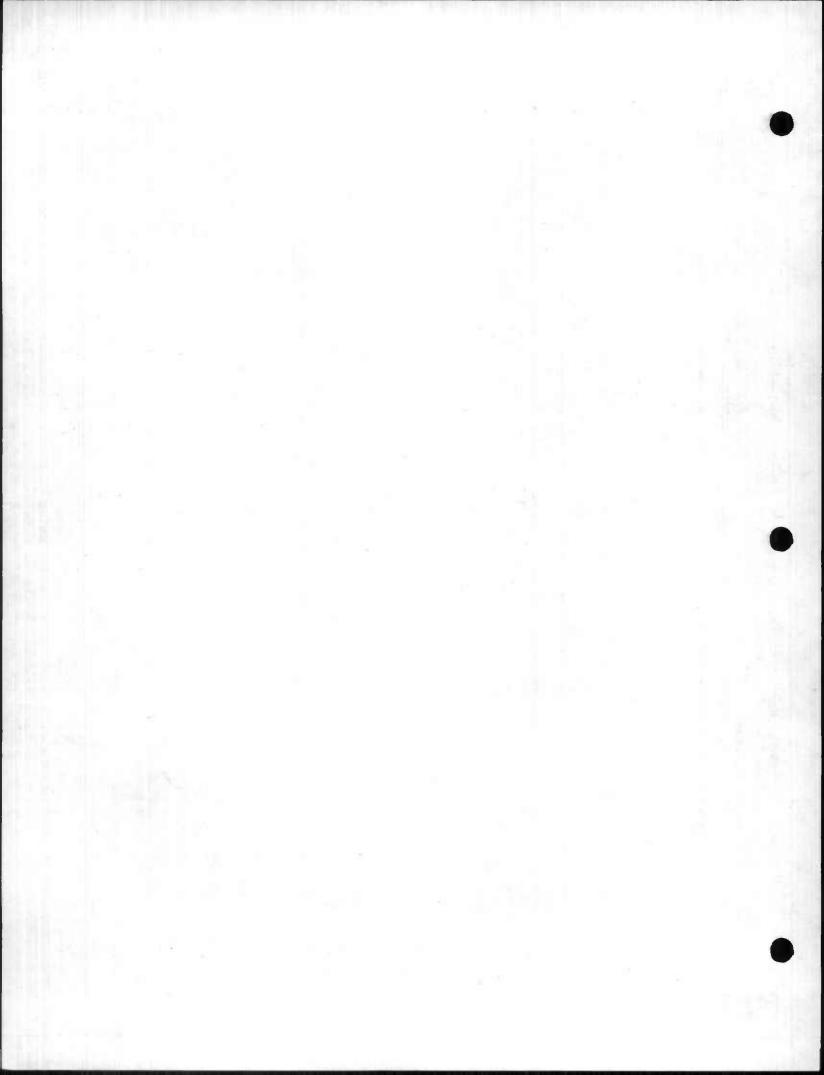
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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Year **Physician** MATTHEW PAUL CARROLL, SR. JANUARY 13. 1999 3:30PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 7330 Crain Highway La Plata Charles If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 MM 2□ F 579-52-1016 87 Director September 21, 1911 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified 1 ☐ Yes 2 No Director 289-1 Charles La PLata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 7330 Crain Highway Nems 23a 20646 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after Hygiene. ther than "natural", or its 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Superintendent US Postal Service parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumetic event 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Charles Ignatius Carroll Mary Henrietta Norris Carroll 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 0 5 19a. Informent's Name/Reletionship (Type, Print) Mary H. Smith/Daughter Apt. 35 Beltsville, MD
Date 20c. Location - City or Town, State 11936 Beltsville Dr. 20a. Method of Disposition

1 Burial 2 Cremetion 3 Removel from Stete 20b. Plece of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 1/19/99 Suitland, MD 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee Eles AREHART-ECHOLS FUNERAL HOME P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of Dying, such as cardiac or respiratory arest. 20646 shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Examiner physician and s the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequenca of): P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 2 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 has 1 Yes 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical axaminer? 8 26. Place of Death (Check only one) 1 Yes No Hospital: Other: 4 Nursing Home Specidence 6 Other (Specify) To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manper of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? Certification: After or Attending Natural 2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, it my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signeture and title of cartifier 29d. Date signed (Menth, Day, Year) completed cause of death (Item 23a) (Type) Print) Address of the ORF. WHI FLAM 20 31. Date filed (Mont 32. Registrar's Signature State 1999 Registrar

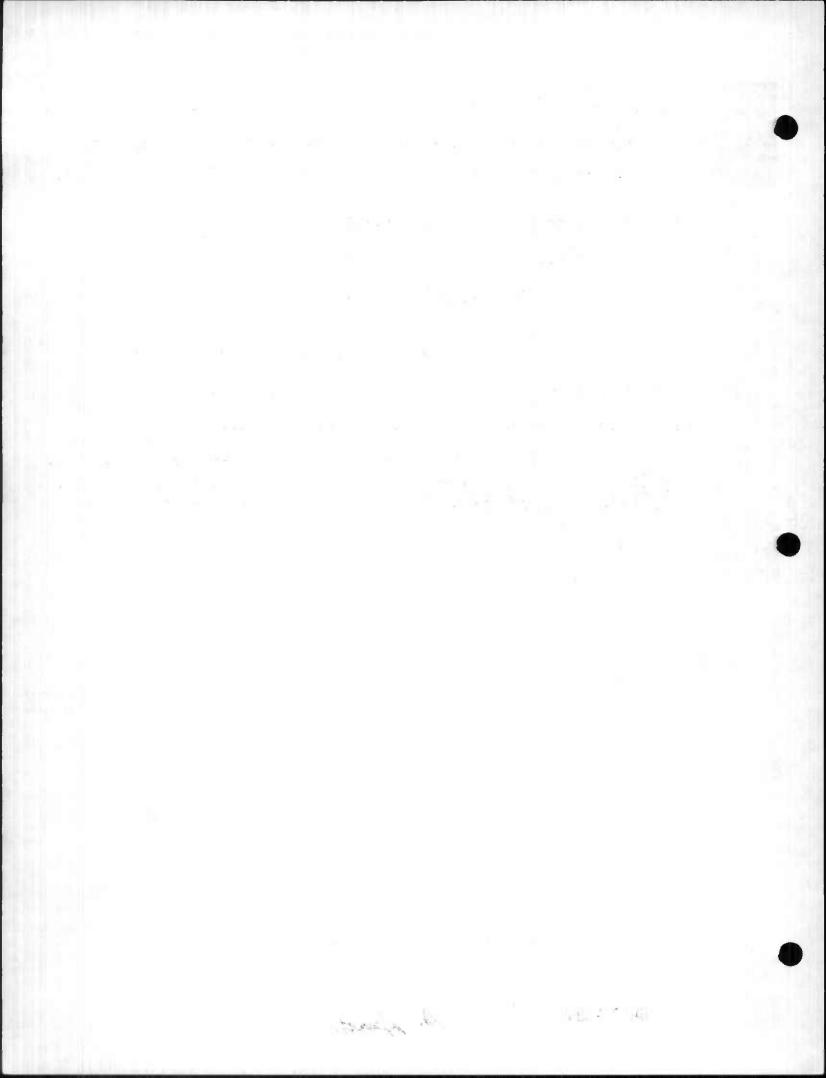


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month 1 - 1 2 - 9 9 **Physician** WILBUR CRAWLEY 15:30 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL Takoma Park Montgomery | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth (Month, Day Year) | 9 - 1 4 - 2 6 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Aga (In yrs. lest birthday) **Funeral** 10XM 2□ F 72 Yrs. Director 577-40-1171 Wash, D.C. Usuel Residence of Decedent the Marylenc 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits mat be notified at 1 Yes 2 No Maryland Prince George Directo Hyattsville 10e. Street end Number 10g. Citizen of Whet Country? with 6625 22nd Place Funeral 20782 USA death 7 is marked other then "natural", or heme traumatic event, the Modical Examiner m. 13. Was Dacedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indien, Bieck, White, etc. 11. Maritai Stetus 72 hours efter 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√☐ No Specify: by Specify: Black 3 Widowed 4 Divorced 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elamentary/Secondery (0-12) College (1-4or 5+) Mental Health Counselor Govt. 12 permit. Pages 1 end 2 should be file Department of Heelth end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event page. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) ROBERT CRAWLEY LUCILLE GUSSOM 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6625 22nd Pl, Hyattsville, Md. 20782 Carrie Crawley -Wife 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20c. Location - City or Town, Steta 1 Buriei 2 Crametion 3 Ramoval from Stete 1-15-99 Washington, D.C. 4 Donation 5 □ Other (Specify) Glenwood Cemetery 22. Name end Address of Fecility Universal Mortuary Inc. 21. Signature of Funerei Service Licensee 411 Kennedy St, N.W., Washington, D.C. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Intervel Between Onset and Deeth **Physician** /Medical Immediate Ceuse /Finel Recurrent Gastric Carringma Few weeks diseesa or condition resulting in deeth) Examiner Due to (or es e consequence of) physician and the buriel-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequence of) use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? á 1 ☐ Yes 2 ☐ No 3 ☐ Probably 400 Unknown Hypertension signed b Records, p 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24e. Was an autopsy performad? It sided arebrovasenlar Accident altered mental status 20 No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospital: 1€Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Ves 20 No funeral 27. Manner of Deeth Certification: 28b. Time of Injury 28e. Dete of injury (Month, Dev Year) 28c. Injury et Work? 28d. Describe how injury occurred After Naturel 5 Pending or Attending efter death. Director: Aft 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Spacify) 2 4 Homlcide To the Hospital of within 24 hours of To the Funeral Discompletely filled in cai 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) Med end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) JAN 121 D 53411 D 30. Name end eddress of person who completed cause of death (Itam 23e) (Type, Print) JC Shesadri, 3060 #103 mitchellville Rd Bowle 20716 31. Deta filed (Month, Dey, Year)

JAN 1 4 1999 Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

						State o	f Mar	yland /				lealth and Death	Mental H	lygier Reg. I		U	1) 4	
			1. Decedent's Nem	e (First, Middle,	Last)							2. Dete of	Deeth			3. Tim	e of Deeth
	Physicia		JOSEPH	PIUS	Di	MISA							JANUA	ARY	Dy, 19) §°\$′	8:1	5AM
M	/Medic Examin		4e Facility Neme (If not institution,	give :	street end nu	mber)					4b. City, Town, o	r Location of De		4c. County			
	Examili	21	2308 P	INEFIE	LD	ROAD						WALDO	RF		CHĀF	RLES		
ŀ	Funeral		5. Sociel Security N	Number (6. Sex	X 2□ F	7. Age (i	n yrs. lest b	irthday)		r 1 Year			Birth Vo	or!	9. Birth	plece (Ste	te or Foreign
L	Director		579-40-21 Usuel Residence o	103	10	14M 2□ F	6	7	Yrs.	Months	Deys	Hours Mi	NOV.	Dey. Ye			HINGT	ON DC
	the Maryland 28a-f show notified at	ctor	10e. State	10b. County CHARLE	S		11	WALD		cation								e City Limits
	ith with the Maryla 23a or 28a-f show	ai Director	10e. Street end Nu	mber D8 PINEF	ΙE	LD ROA	D			10f. Zip	0601				Citizen of N			
020	or items	by Funerai	11. Maritel Stetus	ied 2[XMarrie		12. Was Dec	edent Eve orces? 2 No ve	1951 1952	-	Ves Dece Yes, spe		Hispanic Origin? en, Mexican, Pue Specify:	Specify Yes or erto Rican, etc.)	No-	Blad	ca - Americk, White		١,
21215-0020	C 61	Completed	Etementery/Seco	15. Decedent's cify only highest andery (0-12)	Edu	cation e <i>completed)</i> College (1-4or 5+)	16	(Give I		ork done se retire	during most of w	orking		. Kind of B			
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Baltimore,	S + = 0			position Cremetion 3 5 Other (Spe		temoveyfrom	100		ery, cren	natory or	other ple	AL CEM.	Date 1/15/99		Location -			В
Balt	permit. Page Department of Important: If any Injury or		21. Signeture of Fu	ID A. GO)FF	MO	1098	48	0 3	035 (OLD	ess of Fecility WASHINGT	ON ROAD) WAI				D 2060
п			23a. Part1. Enter t shock, or hee	the disease, or c ort faiture. List o	ompli nly or	ications thet one cause on e	eech iii	eeth. Do	not ente	er the mod	de ot dyl	ng, such es cardi	ac or respiretor	y errest,				mete Between nd Deeth
	Physician /Medical Examiner		tmmediate Ceuse disease or condition resulting in deeth)	on	•	ə	LUN	G CAI	NCER	}						1	Mo	
	P ===	iner			_ ,		Du	e to (or es	e conseq	uence ot)	•							
,00	ite be axecuted lysician end he buriel-trensit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Ceuse (Disease or	enditions, mmediate erlying			Du	e to (or es	conseq	uenca of)								
x 68760,	leath certificate be axecuted attanding physician end I for use es the bunettrensit	Medical	that initiated event resulting in deeth)	S		1.	Du	e to (or es	conseq	uenca of):								
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Records,	been s	Completed										4.7		as en a		8	Vere autop veiteble pr ompletion if deeth?	osy tindings nior to of cause
Re	0 - 0	E O											1	□ Yes	2 No	1	Yes	2 No
Vital	ysician: The	Bec	25. Was case reter	rred to medical								26. Plece of D	eeth (Check on	ly one)				
1	5 00	2	1 Yes 2	No	+	lospitel:	Inpatient	2 ER/0	Dutpetien	t 3 🗆 D	OA OI	her: 4 Nursing	Home 5 XR	esidence	e 6 Dott	ner (Spec	cify)	
ion of	Ing After Tune		27. Menner of Deel 1 XNeturel 2 ☐ Accident	th 5 Pending investige		28e. Dete (Mon	ot tnjury th, Dey Y	ear) 28b	. Time of Injury	М	28c. tnju Wo 1 🗀	ry et ork?] Yes 2 ☐ No	28d. Descri	be how I	Injury occu	rred		
Division		Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could no determin	ot be ned	28e. Place build	a of Injury ing, etc. (- At home, Specify)	tarm, str	eet, fector	y, office		28f. Location City or	n (Stree Town, S	t end Num tete)	ber or Ru	re/ Route /	Vumber,
	e Hospital or 24 hours efte Funeral Dir bletaly filled in	edicai C	29e. Certifier (Check only one)	1 Certifying 2 Medical E	Phys	ner: On the b	best of n asis of ex mer state	aminetion e	ge, deeth	occurred	et the ti	ime, dete end ple opinion, deeth oc	ca, and due to t curred et the tin	he ceus ne, date	e(s) end m end ptaca,	enner es end due	steted. to the ceu	se(s)

State Registrar

31. Dete tiled (Month, Dey, Year) JAN 1 5 1999

29b. Signeture end title of cartitier



30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Moon

KRISHAN MATHUR, MD., P.O. BOX 2729, LA PLATA, MD

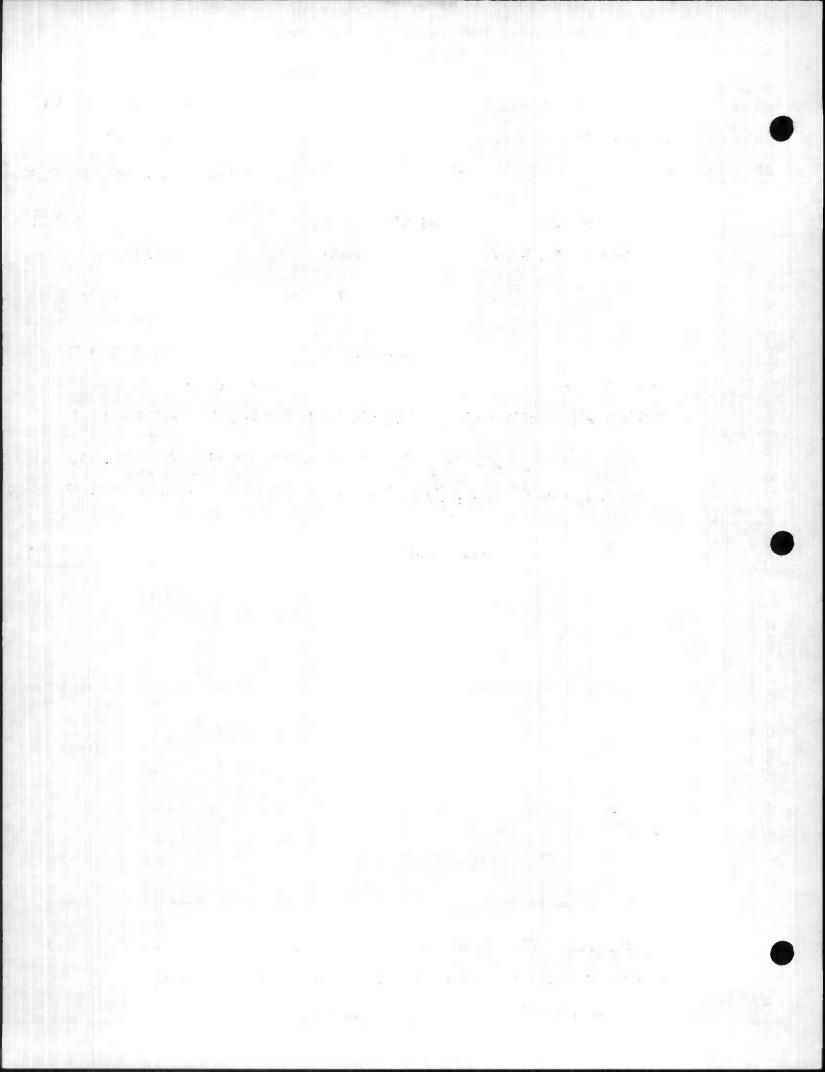
29c. License number

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29d. Dete signed (Month, Dey, Year)

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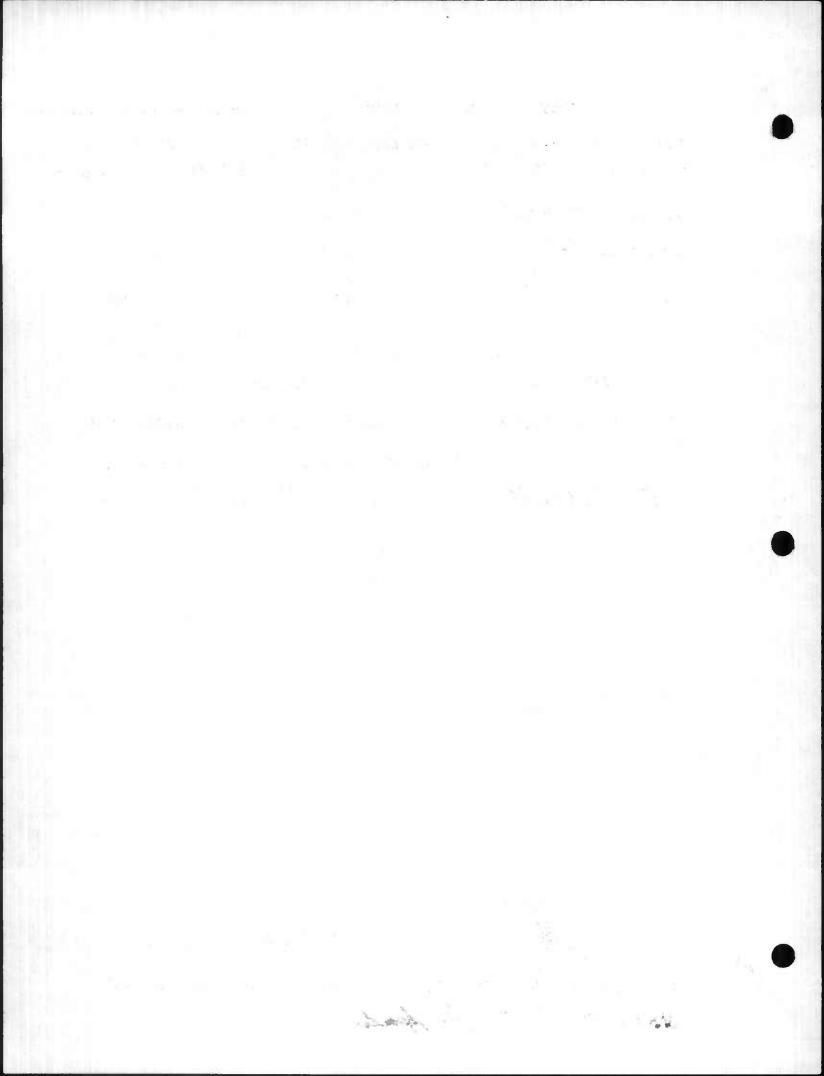
JANUARY 11, 1999



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State of Maryland / Department of Health and Mental Hygiene 9 9 9 4 4

						Cert	tificate of	Death			Reg. No.			
			1. Decedent's Neme (First, Middle, La	st)						2. Dete of De Month		Vaar	3. Time	of Deeth
	Physic /Medi		Fra	nk J.	•	Dav	vis			Januar		Year 99	6:25	A.M.
	Exami		4e. Fecility Neme (If not institution, give	e street and number)				4b. City, To	wn, or Lo	ocation of Deet	4c. Count	y of Deeth		
			Mariner HealthCar					Clin		,	Princ			
	Funeral Director			Sex XXM 2□F 80	(In yrs. last bii	Yrs.	Months Deys		Min.	8. Dete of Bir 11/26/	th 18 (Sear)	9. Birthp Coun Wash	plece (State htp) ingto	or Foreign
	Meryland a-f ahow	ctor	Maryland Prince G	eorge's	10c. City, Tow	m or Loca Dist	ation Crict He	ights				1	0d. fnside (City Limits
	th with the 23a or 28	al Director	10e. Street end Number 2013 Marbury Dr.				10f. Zip Code 2074	7			10g. Citizen of US		ntry?	
Baltimore, Maryland 21215-0020	n 72 hours after death with the Meryland "natural", or frems 23a or 28a-f ahow solicel Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Never Merried 2 Merried \$\infX\text{Widowed} 4 Divorced	12. Wes Decedent E Armed Forces? Wayyes 2 Notes		lf I	Ves Decedent of Yes, specify Cul	oen, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	Ble	ce-Americ ock, White, Whi	etc.	
5-0	72 h	etec	15. Decedent's E	ducation ade completed)	16e	(Give k	ent's Usuel Occu	during mos	t of work	ing	16b. Kind of E	lusiness/Ind	dustry	
121		Completed	Elementery/Secondery (0-12)	College (1-4or 5-	P) B		o <i>noru</i> se retin	,			Feder	o1 Co		t
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lan	ould be filed with Mental Hygiens. arked other than etic avant, the	To Be		M. Davis						et A. K				
ary	E E E	-	19e. Informent's Name/Reletionship (Type, Print)	198	. Meiling	Address (Stree	t end Numb	er or Run	al Route Numb	er, City or Town	, State, Zip	Code)	
Z	eith er 27 is 27 is		Mary T. Piperni/	Daughter	9	800	Kisconk	o Rd.	Ft.	Washing	gton, MD	. 207	44	
ore,	of Heeli of Heeli fitem 2 r other		20e. Method of Disposition		20b. Pieca o	f Disposi	ition (Name of atory or other pie			Dete	20c. Location			
Ĕ	Pag ent nt: h		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif		Resur	rect	ion Cem	eterv	1/15	5/99	Clinto	n MD.		
alt	Departm Departm Importa any inju		21. Signature of Funerel Service Licar	1500			Neme end Addr				lome P	Δ		
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			Pirt1. Enter the disease, or com- nock, or heart fellure. List only	pilcatiuns/thet caused	the deeth. Do								Approxime Interval Be	ete
P	Physician /Medical Examiner	1	Immediate Cause (Finel disease or condition resulting in deeth)	A	Hem	050	leron	CO	44) DUAS	culter!	DIRSA	Onset and	
		ē	resulting in deeth)	, , ,	Due to (or es a	consequ	ienca of):						/	
o,	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying	b	Due to (or es a	consequ	ence of):					-		
x 68760,	certificate be executed office to the control of th	Medical	Cause (Disease or injury that initiated events resulting in deeth) Last	c	lue to (or as e	conseque	ence of):					-		
Box	death c	Physician	Part II. Other significant conditions of	ontributing to death but	not resulting i	n the und	deriving cause o	iven in Pert	f.	23b. Dld	tobacco use co	ontribute to	the cause	of death?
, P.O	the sch	by Phys	- NON	Healing	Hip	1 6	MITH	WIS			Yee 2□ No			Unknown
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= =	The ate h	Con								10	Yes 2 No	10	Yes 2	□No
/ita	ysician: The s certificate director, pag	Be	25. Wes case referred to medical axeminer?							h (Check only o				
of	5 00	2	1 ☐ Yes 2 Ñ No	-	t 2 ER/O		3LI DOM		7		dence 6 □Ot		(y)	
sion	The The	Certification:	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident investigation 3 Sulcide 6 Could not b		Year) 28b.	Time of Injury	28c. Inju Wo M 1	iry at ork?]Yes 2□	No		how injury occu			
Divi	tal or Attand rs after death ai Director: /	Certifi	3 Sulcide 6 Could not b 4 Homlcide determined	28e. Pleca of Injui building, etc.	ry - At home, fe (Specify)	erm, stree	et, fectory, office			28f. Location (City or To	Street and Num wn, State)	ber or Rura	al Route Nu	mber,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	29e. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	yalcian: To the best of hin be basis of menner stet	examinetion en	e, deeth o	occurred et the t estigetion, in my	lme, dete ar opinion, dec	d plece, oth occurr	end due to the red et the time,	ceuse(s) and m dete and place	anner as si and due to	tated. the cause	(s)
	To the within 2 To the comple	M	29b. Signeture and title of certifier	F			20ks trican	194	13)		29d. Dete sign January			
	(12)		30. Neme and eddress of person who	1			-)3 Er	I.I.	chinata	on MD (207//		
	Sta	te	Frank M. Ryan,	32. Registre		scon	Rd. #20	,, rt	. wa	SHIRE	711, FID 2	20744		
	Registr	22.50	JAN 1 2 1999	Benevy	B	ba	del							



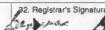
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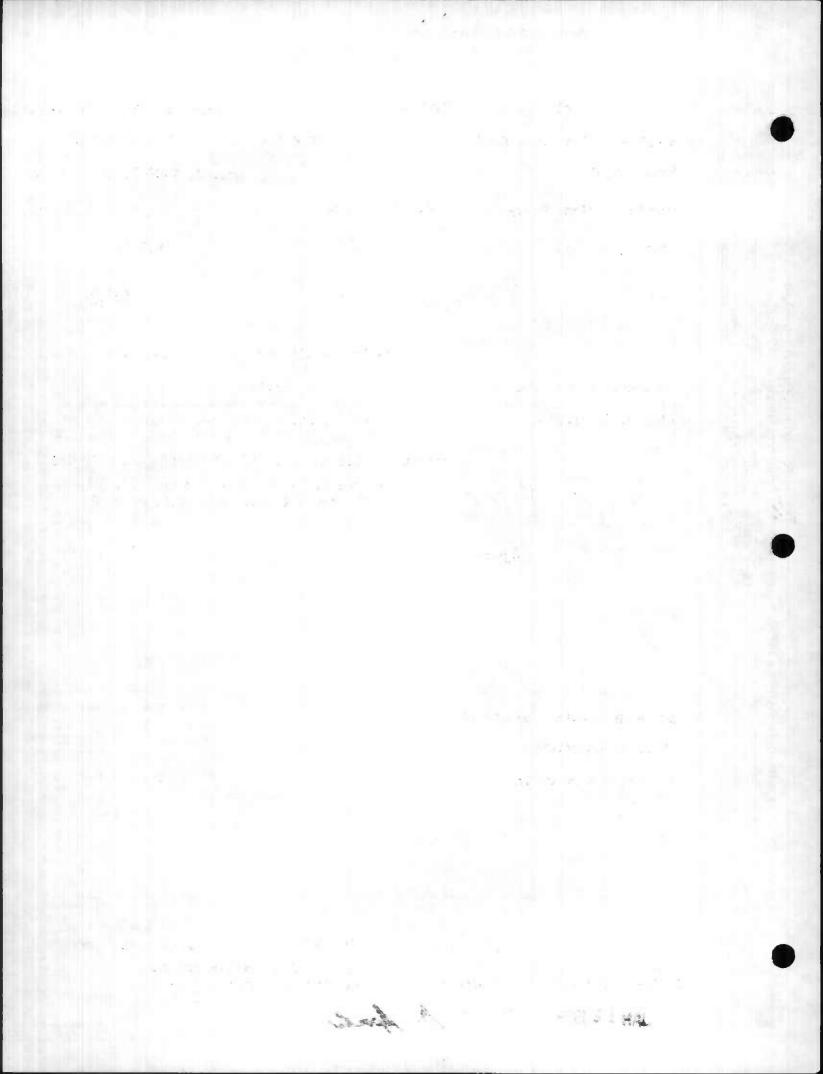
	4 Decedent None (F) 4 Mars 1	204)	Ce	ertificate	of	Death			eg. No.		2 Time - of D - 11
hysician	1. Decedent's Name (First, Middle, L Ale jandrin		umlao					2. Date of Deat Month JANUARY	Day	Year	3. Time of Death 10:45 A.M
/Medical Examiner	4a Facility Name (If not institution, g		4		4	4b. City, To		cation of Death	4c. County		10.45 A.M
Kalliller	MALCOLM GROW MEI	ICAL CENTER			C	CAMP S	SPRIN	GS	PRINCI	E GEO	RGE'S
ıneral			rs. last birthday	/) If Under 1	Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
tor	578-42-8146	1□XM 2□ F 89	Yrs.					oct. 2,	1909	Phili	ppine Is.
	Usuat Residence of Dacedant 10a. State 10b. County	10c. (City. Town or I	ocation						1	0d. inside City Limits
by Funeral Director	Maryland Prince	George's	Fort Fort	Washing	gtor	1					1 ☐ Yes 2 🛣 No
Tec.	10e. Street and Number		-	10f. Zip C	Code			1	0g. Citizan of \	What Cour	ntry?
O	8228 Clay Drive	9		207					U.S	. A .	
by Funeral Director	11. Marital Status	12. Was Decedent Ever in	U,S. 13	. Was Deceda	nt of H	lispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)			can Indian,
3	1 Never Married 2 Married	Armed Forces? 1 ▼ Yes 2 □ No If Yes, Give		1 ☐ Yes 2		Specify:	i, Puerto i	ncan, etc.)		k, White, Asia	
	3€Widowed 4 □ Divorced	Year or Dates:1929	1-46	10 165 22	2 140	эреспу.			Specin	Fili	pino
etec	15. Decadent's (Specify only highest g	Education rade completed)	16a. Dec	edent's Usuat e kind of work DO NOT use	Occup done	ation during mos	t of workir	ng	16b. Kind of B	usiness/In	dustry
dm	Elementary/Secondary (0-12)	College (1-4or 5+)							II C	AT T	
S	17. Father's Name (First, Middle, Las	st)		Retire	7 _		-	(First, Middle, I	U.S. Maiden Suman		
To Be Completed	Melchor Farne	Dumlao				J	ovita	ı I	Inknown		
-	19a. tnformant's Name/Ratationship		19b. Mai	ling Addrass (Street			Route Number		State, Zip	Code)
	Alex P. Dumlao/	Son	8228	Clay I	Dr.	Ft.	Washi	ngton,	MD 207	44	
	20a. Method of Disposition		Placa of Disp	oosition (Name amatory or oth	e of ner plac	ca)		Date	20c. Location -	City or To	own, State
	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		lingto	n Natio	ona.	1 Cem	. 1/	15/99 A	rlingt	on, V	irginia
	21. Signature of Funeral Service Lic	ensee 1		22. Name and	Addre	ss of Facili	y Fi	neral H	Iomo P	Δ	
	Theoryes	Halas		6160	oxC	n Hil	1 Rd.	Oxon F	Hill, M	D 207	45
	23a. Part1. Entar tha disease, or co shock, or heart failure. List on	mplications that caused the de y ona causa on aach lina.	eath. Do not e	nter the mode	of dyin	ng, such as	cerdiac o	r respiratory arr	est,		Approximate Intervat Batween
n il	In-realization Course (Fig. 4)									į	Onset and Death
	Immediata Causa (Finat disease or condition resulting in death)	a. SEPSIS								3	DAYS
er		Dua to	(or as a conse	equenca of):						1	
min	Commenter to the first and divines	b	(or as a conse	equence of):						i	
EXS	Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated avants	20010	(0) 43 4 00/130	squerios orj.							
dicai Examiner	Cause (Disease or Injury that initiated avants resulting in death) Last	C. Due to	(or as a conse	equence of):							
	resulting in death) Last									1	
by Physician/Me		d								- 1	
/sic	Part II. Other significent conditions	contributing to death but not re	esutting in tha	undarlying cau	use giv	ran in Part	l.	23b. Did to	becco uee co	ntribute t	o the cause of death?
Ph	ACUTE MYOCARDIA	INFARCTION						1 🗆 Y	es 21 No	3□ Pro	bably 4 Unknown
								24a. Was a	n autonsv	24b. W	ara autopsy findings
Completed	ACUTE RENAL FAIL	LURE						perion		av	aitable prior to impletion of cause death?
my	AT SUPPLIED LA DING							4 🗆 V	es 2 No		☐ Yes 2☐ No
	ALZHEIMER'S DEM	ENTIA				OC Phon	of Dooth	(Check only or		11	Tes 2 No
To Be	examiner?	Hospital:	☐ ER/Outpatio	ent 3 DOA	Oth	95.		ne 5 Reside		er (Snecil	6v)
n: T	27. Manner of Death	28a. Date of Injury	28b. Time		c. Injur Wor			28d. Describe h			,,
atio	1 XNaturat 5 ☐ Pending 2 ☐ Accident investigati		tnjury	М		Yes 2	No				
Certification:	3 Suicide 6 Could not 4 Homicida determine	be d 28e. Placa of Injury - At building, etc. (Spe	home, farm, s	treet, factory,	office		2	28f. Location (Si City or Town	treet and Numl n, State)	per or Rura	al Route Number,
Medicai		hyelclan: To the bast of my k miner: On the basis of exami and manner stated.									
Mex	29b. Signature and title of cartifier	and mathrer stated.		29c.	Licens	e number		2	9d. Date signe	d (Month,	Day, Year)
	> Sharon	R OBries	4	D-	-52	353		JA	NUARY	08. 1	999
	30. Nama and addrass of person wh		tem 23a) (Type	Print) On	MTM	C/10F	Λ 1.1 T	PERIMETE			
	SHARON R.O'BRIEN					-		20762-			

State Registrar

31. Date filed (Month, Day, Yaar)

AN 1 2 1999





Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours aftar deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Medical Exameration and an once.

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours efter death.

To the Funeral Director: After this cartificate has been signed by the ettending physician end completely filled in by the luneral director, page 2 should be detached for use as the bunal-trensit

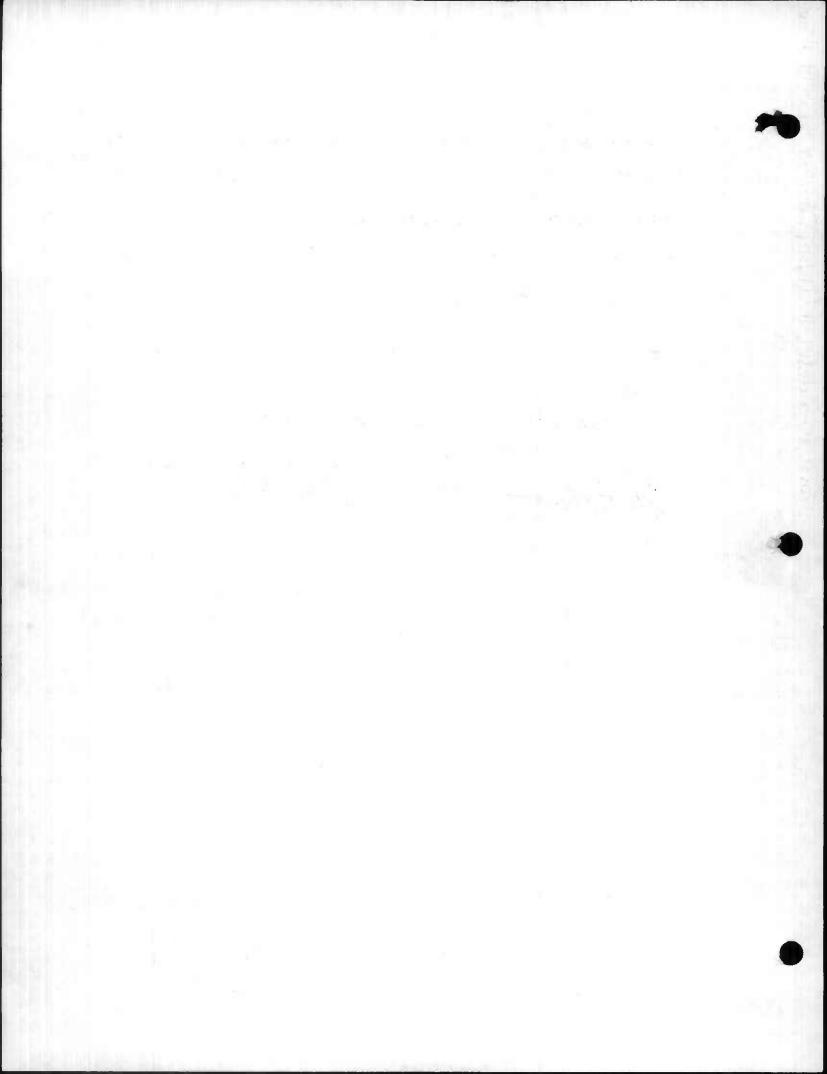
Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Mar	-	Departme Certifica					jiene 9	y (1941	0
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in a	WENDELL L. FORI							JANUARY	11 19	Yaar 199	11:52	AM
ai er	4a. Facility Nama (If not institution, giva	streat and number)			14	b. City, To	wn, or L	ocation of Death		ity of Death		
	Charlotte Hall V	/eterans' H	Iome		C	harlo	tte	Hall	St M	lary's		
	Social Security Number 6. Sa		In yrs. last birl	Month	lar 1 Yaar s Days	If Undar Hours	24 Hrs. Min.	8. Data of Birth (Month, Day	Year)	9. Birth	placa (Stata or ntry)	Foraign
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_	10a. Stata 10b. County		0c. City, Towr	or Location							10d. Insida City	
cto	Maryland St Mary's	5	Char1c	tte Ha	11						1 🗆 Yas	2 No
Funeral Director	10e. Straat and Numbar			10f. 2	Zip Coda	00		1	0g. Citlzan o	f What Cou	ntry?	
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-	19a. Informant's Name/Relationship (T)	vpe, Print)	19b.	Mailing Addre	ss (Street	Unkr		al Routa Numbe	r. City or Tow	n. Stata. Zii	n Coda)	
	Reed C. Scott (PI	RD)						a, VA 22		.,,		
	20a. Mathod of Disposition		20b. Placa of	Disposition (A	lama of		T	т т	20c. Location	- City or T	own, Stata	
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an/		4 1)-	· ma	4710								
SICE	Part II. Other significant conditions cor	ntributing to death but n	ot rasulting in	tha undariying	causa giv	an In Part I		23b. Did to	becco use c	ontribute t	o the cause of	death?
July 1					_			1 □ Y	es 2 No	3 □ Pro	bably 420	Inknown
by		use c	CUSO	8 de	0	_						
Be Completed by Physician/Med								24a. Was a perform	n autopsy med?	81	ara autopsy fin vailabla prior to emplation of ca daath?	
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o o	axaminar?	Hospital:	2□ ER/Out	tpetient 3 1	Oth	IU.	-	th (Check only or oma 5 🗆 Raside		the Const	4.1	
-	27. Manner of Death	28a. Data of Injury (Month, Day Y		ime of	28c. Injun		ising no	28d. Dascribe h			(4)	
0	1 Accidant 5 Panding investigation	(Month, Day Y	ear) ir	njury M		k? Yas 2∐	No					
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Medical Certification: 10	29a. Cartifiar 1 Certifying Physic (Check only one) 2 Medical Examination	alcian: To the best of m	amination and	, death occurre	ed at tha tim	na, date an olnion, daa	d place, th occur	and dua to tha c red at the time, d	ausa(s) and nata and place	nannar es a	stated. o tha cause(s)	
M M	29b. Signatura and titla of certifiar	and mannar stated		9	9c. Licans	number		0	9d. Data sign	ned (Month	Day Yearl	
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B. Sparke

State Registrar

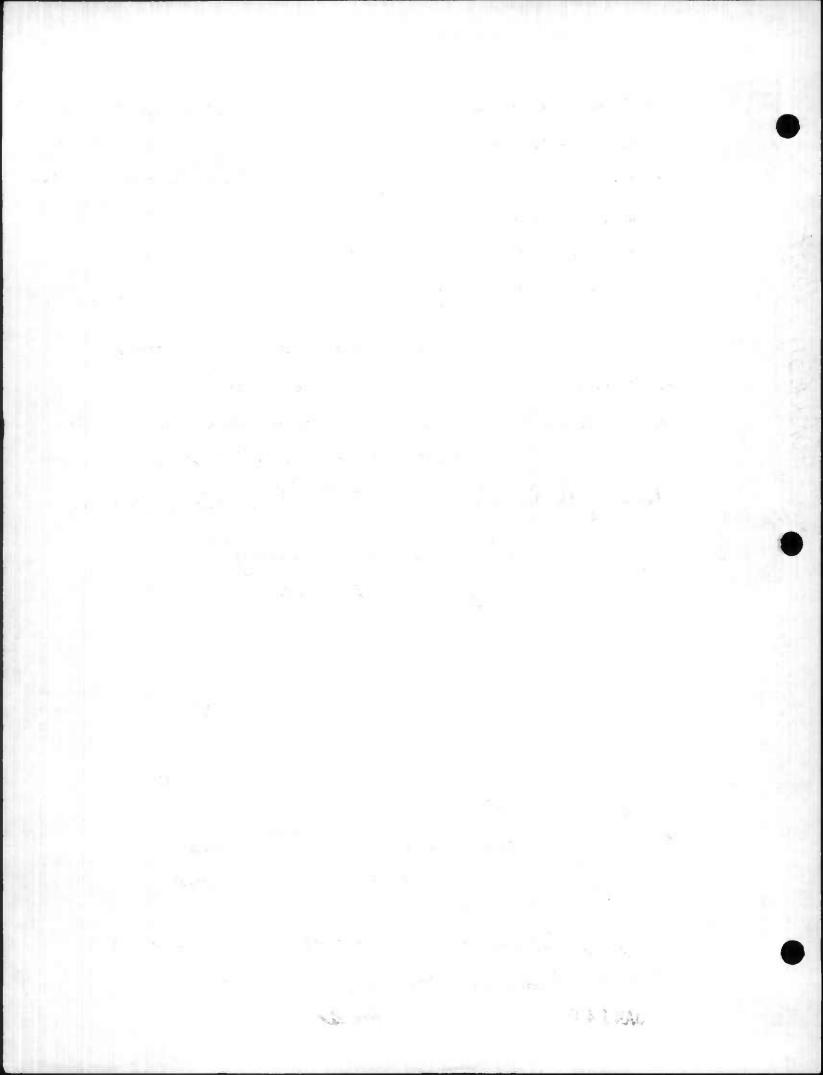


State of I	Maryland /	Depa	artmer	nt of	Healt	h and	Mental	Hygiene
		_						

Physici /Medic		1. Decedent's Name (First, Middle, Las	st)		rtificate of		2. Dete of Deat	eg. No. h	3. Time of Death	-
/iviedit		ELBERT MCKINLE	Y FORRIEST				Month	Day O.	999 1:588	1
Examir	- 0	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or L	ocation of Death	4c. County	7.1	
		Doctors' Communi	ty Hospital			Lanham		Prin	ce George's	
Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		Birthplace (State or Forei Country)	igr
Director		182-26-1601	ØM 2□ F	64 Yrs.	Months Days	Hours Min.	May 21	1934	North Carolin	18
		Usual Residence of Dacedant 10a. Stete 10b. County	100	City, Town or Lo	cation					
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r 28a-f show a notified at	ect	10e. Street and Number	eorge s	capicoi	10f. Zip Code			0		_
23n or Mat be	Funeral Director	109 East Mill Av	renue		2074	3	1	U.S.A	What Country?	
ral', or Items Examiner in	by	11. Meritel Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces?1 X Yes 2 □ No If Yes, Give Year or Dates:	1901	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🔀 No	Hispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Ricen, etc.)		ee - Americen Indian, ck, Whita, etc. v: Black	
hatn	Completed	15. Decedent's Ed (Specify only highest gra-	ucation	16a. Deced	lent's Usual Occup	pation during most of work od)	ina	16b. Kind of B	usiness/Industry	_
Mes.	npie	Elementary/Secondery (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	Musician	ing	D		
A Bert	Cor	12th		FLOTE	SSTONAT			Priv		
d off	Be	17. Father's Name (First, Middla, Last) Elbert Forriest				18. Mothar's Nam		Aaiden Suman	ne)	
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The property of the property o		19a. Informant's Name/Ralationship (7) Karen F. Forries				t and Number or Rur				
Day 2		20a. Mathod of Disposition					-		City or Town, State	_
in in in		1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cometery, cren	sition (Nama of netory or other pla	ce)	01/10			
riting right	-	4 ☐ Donetion 5 ☐ Othar (Specify 21. Signature of Funeral Service Licen:				s Ceme. 1	999	nerten	ham, Maryland	
Depa mpo any any		21. Signature of Pulleral Service Licent	0 +'	Ĵ	. Name and Addre	INS FUNER	AL HOME			
hysician /Medical ixaminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediata Cause (Final disease or condition		eath. Do not ente	er the mode of dyi	ng, such as cerdiac	or respiratory arre	est,	ryland 20785 Approximate Intervel Between Onset and Death	
	-e-	resulting in death)	P as Due to	(or as a conseq	uence of):	e Lui	9			
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iclan and bunal-trensi	EXS	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated evants) Due (c	(or as a corport	derice or).					
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0 0		resulting in death) Last								
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ed by the attendir deteched for use	Physician/	Part II. Other significant conditions co	ntributing to death but not i	esulting in the ur	nderlying ceuse giv	ven In Part I.	23b. Did to	bacco uae coi	ntributa to the causa of deat	h?
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is been signed by the attending physician and 2 should be deteched for use es the bunal-tree	Completed						24a. Was ar perform		24b. Were autopsy findings eveilable prior to completion of cause of death?	í
ate has b	E						1□ Ye	s 2 No	1 ☐ Yes 2 ☐ No	
	Bec	25. Was cese referred to medicel				26. Place of Deat			1831 1732	
O io	To	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	hor:	me 5 Reside		er (Specify)	
or this certific eral director,		27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injui Wo	ry at N/A	28d. Dascribe ho	w injury occur	red	
2 2	satic	2 ☐ Accident investigation	NIA	NA		Yes 2 □ No	N/	4		
or: After he fune	Ë	3 Suicide 6 Could not be datermined	28a. Place of Injury - A building, etc. (Spe	t homa, farm, stre	eat, factory, office		28f. Location (Str City or Town	eat and Numb , State)	per or Rural Routa Number,	
efter death. Director: Affe	ē			nouledge doeth	, , ,	me date and place	and due to the ce	usa(s) and ma		
24 hours effer death. Funeral Director: After stely filled in by the fune	dical Cer	29a. Cartifiar (Check only one) 1 Certifying Phy	iner: On the basis of exami	nation and/or inv	estigation, in my o	ppinion, death occurr	ed at the time, da	ite and place,	end due to the cause(s)	
ithin 24 hours efter death. the Funeral Director: Afte xmpletely filled in by the fun	Medical Certification:	one) 2 Medical Exam	alcian: To the best of my k iner: On the basis of exam and manner statad.	ination and/or inv	estigation, In my o	opinion, death occurr	ed at the time, da	ite and place,	end due to the cause(s)	
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Registrar

JAN 1 4 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 99 01 10 8:38 pm Reginald B. Groomes 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Southern Maryland Hospital CLINTON Prince George's If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days 1 M 2 □ F 39 Yes 577-86-7378 6 - 20 - 59Wash., D.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No D.C. None Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3502 7th St., S.E. 20032 USA 14. Rece - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Maintenance 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Delavan Groomes Alberta Flemming 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alberta Groomes, Mother 1315 Maryland Ave., N.E., Wash., DC 20002 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 1-16-99 Clinton, Md. Forest Hills 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ralph Williams Funeral Service Ween 517 11th St., S.E., Wash., DC 20003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death It is Nephere Paty Immediate Cause (Finel diseese or condition resulting in death) Due to (or as a consequence of): HyBte-Son Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Septes Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

The law requires that the deeth certificate be executed

Box 68760,

Records, P.O.

of Vital

Division or Attending this

Affer

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Be

10a. State

Funeral

Director

with the Marylend

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Department of Health end Mentel Hygiene. Important: If Item 27 ie marked other than "natural", or Herm 23a or 28a-1 show with figury or other traumatic avent, the Medical Examiner must be notified at page.

21215-0020

Baltlmore, Maryland

Physician/Medical Examiner physicien and the buriel-transit þ Be

Completed pege 2 Certification: To funeral To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. edical

0

State Registrar

JAN 1-3 1999

29b. Signature end title of certifier

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be determined

1 Yes 2 2 No

27. Manner of Death

1 PNatural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

Dancemn.

29c. License number D25640

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year) January 11,1999

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1328 SOUTHERN AVE WASHINGTON OC 20032 DAVACHI, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature the co

Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Dete of Injury (Month, Day Year)

DHMH 16 Rev 6/95

DEDERIC GARTRELL -CATHEY

State of Maryland / Department of Health and Mental Hygiene

Certificate	of Death

If Under 1 Yaar Months Days

10f. Zip Code

Days

Physician /Medical Examiner

Directo

Funeral

þ

Completed

Be

Dedric 4a Facility Nama (If not institution, giva street and number)

1. Decedent's Nama (First, Middla, Last)

Gartrell-Cathey

2. Data of Death Month Day JANUARY 6, 1999 3. Time of Death 1645 PM

2515 SOUTHERN AVENUE 6. Sax 1 M 2 □ F 7. Aga (In yrs. last birthday)

Brian

4b. City, Town, or Location of Death TEMPLE HILLS

If Under 24 Hrs.

Hours

4c. County of Death PRINCE GEORGES

Euneral Director

28a-f

b must be

Berns 23a

8

"natural".

permit. Pages 1 and 2 should be I Department of Health and Mental Important: If Item 27 is marked of any Injury or other treumatic eve

Physician

/Medical **Examiner**

physician and the burial-tran

88

page

this

s after death.

I Director: After death of the function of the

To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 1

Box 68760,

P.O.

Records,

Division of Vital

Attending

Examine

Physician/Medical

by

Completed

Be

10

Certification:

edical

Pages 1

Baltimore, Maryland 21215-0020

10a Stata 10b. County

27 10c. City. Town or Location

Yrs

 Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) August 22,1971 Washington, DC

217-06-2917 Usual Rasidance of Decedant

5. Social Sacurity Number

District of Columbia

Washington

10d. Inside City Limits 1 X Yas 2 □ No

10e Street and Number

1717 - "S" Street, S. E.; Apt. 208

20020

10g. Citizen of What Country? United States

11. Marital Status

1 Nevar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 M No If Yas, Giva Yaar or Datas:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Yas 2 No Specify:

14. Race - American Indian Black, Whita, etc. Specify: Black

15. Decedant's Education (Specify only highast grada completed)

Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)

Roofer

16b. Kind of Business/Industry

Construction

12th grade 17. Fathar's Nama (First, Middle, Last)

Carl

Cathey

Sallie

18 Mother's Name (First, Middle, Maiden Sumama) Ann

Gartrell

Lee

19a. Informant's Name/Ralationship (Type, Print) (Mother)

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

Sallie A. Gartrell-Cathey

20b. Place of Disposition (Nama of cematary, crematory or other place) Jan. 15, 1999

1717 "S" Street, S.E.; Apt. 208; Washington, D.C. 20020 20c. Location - City or Town, State

20a. Mathod of Disposition

1 Nourial 2 Cramation 3 Ramoval from Stata 5. Other (Specify) 4 Donation

Forest Hills Memorial Gardens

Clinton, Maryland

22, Nama and Addrass of Facility Robert G. Mason Funeral Home, Inc.

21. Signature of Emeral Service Licenses

1661 Good Hope Road, S.E.; Washington, D.C.. 20020

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Dua to (or as a consequence of)

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Immediata Causa (Final disease or condition rasulting in death)

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Dua to (or as a consequence of)

Dua to (or as a consequence of)

23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Wera autopsy tindings available prior to completion of cause of death?

Approximata Interval Between Onset and Death

1 1 Yes 2 No

25. Was casa rafarred to medical 1XX as 2□ No

27. Mannar of Death 1 Natural 2 Accident

5 Panding invastigation 6 Could not be datarmined

28b. Time of Injury 1645 28a. Data of Injury (Month, Day Year) 99

1 Inpatiant 2 ER/Outpatient 3 DOA

28a. Place of Injury - At homa, tarm, street, tactory, office building atc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 8 BOther (Specify) SCON C 28d. Describe how injury occurred Subi

26. Piace of Death (Check only one)

Shot CCT 281. Location (Street and Number or Rural Route Number City or Town, State)

29a. Certifier (Check only onel

3 Suicida

4 Homlcida

Building. 2515 Southern Aug 11/1/5 emple 1 Certifying Physician: To the best of my prowiedge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certific

Hospital:

29c. Licensa number O.C.M.E. 29d. Data signed (Month, Day, Year) JANUARY 7, 1999

30. Name and address of person who complated cause of death (Itam 23a) (Type, Print) 1050

0 taner 31. Data tileti (Month, Day, Year)

JAN 1 2 1999

111 Penn Street, Baltimore, Maryland 21201 32 Registrar's Signatura

State Registrar

L Committee RECORDED MAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Cast) 2. Date of Deeth 3. Time of Deeth J AN A 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death GLEN BURNIE ANNE ARUNDEL 1124 CRAWFORD DRIVE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days Hours 1 M 2 F Yrs. SEPTEMBER 23, 1926 WEST VIRGINIA 235-36-2926 Usual Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No GLEN BURNIE MARYLAND ANNE ARUNDEL 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 21061 1124 CRAWFORD DRIVE UNITED STATES 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) AIR CARRIER RESERVATION AGENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ADA FREEZE JOHN DOWDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1124 CRAWFORD DRIVE, GLEN BURNIE MARYLAND 21061 RANDALL K. GABBERT (son) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT LINCOLN CEMETERY 1/15/99 BRENTWOOD, MARYLAND 22. Name end Address of Fecility
FORT LINCOLN FUNERAL HOME, INC.
3401 BLADENSBURG RD, BRENTWOOD MD 21. Signature of Funeral Service J. Tuenez M00907 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one ceuse of the complex control of the control of th d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 788 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

RIGGELY EVESTE (20 ANNABLI) NO LIVE

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

certificate be executed

any Injury or o

Physician · /Medical

Examiner

Director

Funeral

PV

Completed

Funeral

Director

Item 27 is marked other than "natural", or itema 23a or 23a-f show other traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death of Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23.

al Hygiene.

Baltimore, Maryland 21215-0020

with the Meryland

Examiner Physician/Medical 88 USB for þ Completed Be 2

shysicien end the burial-trans attending physicien the signed by the peed hes certificate director. this uneral After 6

P.O. Box 68760 Division of Vital Records. after deeth. 6 To the Hospital o within 24 hours af To the Funeral DI completely filled in

edical

State Registrar

Certification:

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

290. Signature and titul

31. Date filed (Month, Dey, Year)

JAN 1 4 1999

6 Could not be determined

who comple

3. Registrar's Signature

600

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ause of death (Item 23a) (Type, Print)

Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as steled.

2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and meaner stated.

the spents

JAN 1 4 135

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Dea	ath	Reg. No.		
		1. Decedent's Nema (First, Middla, Last)		of Deeth	Maria	3. Time of Death
Physic /Medi		Gladys Virginia Brittingham Godwin	Mont 0.1		Yaar 99	2130 hrs
Exami		4a. Facility Neme (If not institution, give street end number) 4b. City	ty, Town, or Location of		nty of Death	2130 1118
		Peninsula Regional Medical Center Sal	lisbury	Wico	omico	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yaar If Under 1 Yaa	Indar 24 Hrs. 8. Data ours Min. (Mon	of Birth th, Dey, Yeer) 30/14	9. Birthpi Coun	laca (Stata or Foreign try) yland
2		Usuel Residence of Decadant		9.0.7.1.1	. Har	y Land
show and		10e. Stete 10b. County 10c. City, Town or Location			10	0d. Inside City Limits
e Me	cto	VA Accomac Greenbackville				1 ☐ Yes 2 No
# 20 #	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen o	of What Coun	try?
23a	a	37062 State Line Road 23356		US	S A	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 28 or 28a-f show other traumatic event, the Medical Exaculter trains be notified at	by Funeral Director	11. Marital Stetus 1		or No- c.) 14. R B	lace - Amarica lack, Whita, a cify:	atc.
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C 5 49	Completed	(Specify only highest grada completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	most of working			
gien gien	PO	5 Seamstress		Garm	ent F	Factory
build be filed with Mentel Hygiene. Brked other than attc event, tree	Be		Mother's Neme (First, M	fiddle, Melden Sum	eme)	accory
should be nd Mentel marked c	To	Clayton Brittingham B	Bertie	Mer	ritt	
1 and 2 sho Health end I em 27 is me other traums		19e. Informent's Neme/Reletionship (Type, Print) Emily G. Hart 19b. Meiling Address (Street and No. 18 Somerset A.)				
Page nent c int: If iry or		20a. Method of Disposition 1 Buriel 2 Cremetion 3 Ramoval from Stete 20b. Plece of Disposition (Nama of cemetery, crematory or other place) Downing Meth. Cem	Date 01/07	20c. Location 7/99 Oak	n-City or To	
permit. Departr Importa		21. Signature of Funerel Sarvice Licensee 22. Neme and Addrass of F Whichel A Dean Moll29 103 Linden	Facility Hollowa Av Pocomo	y Melso ke, Mar	n Fun	neral Hom 1 21851
Physician /Medical Examiner	ier	Immediate Cause (Finel disease or condition rasulting in death) a. Endometric Cause (Cause Cause Caus	areen	oma		Onset end Death
The law requires that the death certificate be axecuted ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit	ai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury			1	
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s law requires has been sign je 2 should be	Completed by	Organie Bisin Syndrome.	248.	Was an autopsy performed?	ava	ere autopsy findings allable prior to impletion of cause death?
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	Be C	25. Was case referred to medical 26.6	Place of Death (Check			
Physician: rthis certific ral director,	0	examiner/ Hospital:	□ Nursing Home 5□		thar (Specific	()
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oding I Ith. :: After e fune	atio	1 ⊠Netural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes	2 🗆 No			
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Hospitu 24 hours Funeral	edicai (29a. Certifier (Check only one)	te end place, and due to, deeth occurred at the	o the cause(s) and time, date and place	menner as st e, and due to	ated. the cause(s)
rothir rothir comp	Me	29b. Signature and title of certifier 29c. Licanse number 29c. Lic	iber	29d. Dete sign	ned (Month, I	Day, Year)
->-0		Legania (B.Ol. 6D DO	3500	1 7	_ 00	2
		Name and advance of access who appreciated are of the little and the second access who appreciated are of the little and the l	1000	1-/	- 7	/
3	1	-50. Name and ediffess of person who completed cause of deeth (Item 23a) (Type, Print)	TOV TO	111000		710-1
		GREGORIO M. BELLOSO, M. D. 5302 CHINABET 31. Date filed (Month, Day, Year) 32. Registrar's Signeture	RRY DR., S	MISBUR	Y, MD	21801
Sta Registr	_	JAN 0 8 1999 Denuta B. doors	1			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 952

				Certificate d	of Death		Reg. No.	
	1. Decedent's Name (First, Middle, L	ast)				2. Data of De	ath	3. Time of Death
Physician	Dempsey He	rri ++				Januar		14:45
/Medical Examiner	4e Facility Nema (If not institution, go	iva street and number)			4b. City, Town, o	r Location of Deat		
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Funeral			(In yrs. last birt		ar If Under 24 Hr	s. 8. Data of Bir	Montgo	
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P P	10a. State 10b. County		10c. City, Town					10d. Insida City Limit
F 6	Maryland Montgom	ery	Silver	Spring				1 ☐ Yas 2 ☐ N
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E 5	11. Merital Stetus	Armed Forces?		13. Was Decedent of If Yas, specify C	uban, Maxican, Pus	rto Rican, atc.)	Black,	Whita, atc.
by F	1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 X Yas 2 ☐ N If Yes, Giva Yaar or Datas:	lo	1 ☐ Yes 2 [X]	No Specify:		Specify:	Black
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	Elementery/Secondery (0-12)	College (1-4or 5	+)	(Giva kind of work do lifa. DO NOT use re	tired)		Food Se	rvice
SEE O	17. Father's Nama (First, Middle, Las		Ma	nager	19 Mother's N	ama /First Middle	Maiden Sumama)	
marked other than marke event, the I	Hewitt	N)						
To Be	newitt				Claud	ia Hewitt		
	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Str	eet and Number or I	Pural Route Numb	er, City or Town, St	ate, Zip Code)
- 0 -	Miriam Norton /	Daughter	14	946 Wellwo	ood Road	Silver S	Spring, M	D 20905-5765
item 2 other	20a. Mathod of Disposition	Name Tolk	20b. Place of cemater	Disposition (Nama of	place)	Data	20c. Location - Ci	ty or Town, Stata
Important: If he eny injury or of the	1 Burial 2 □ Cremation 3 I 4 □ Donetion 5 □ Other (Spec			Washingto		1/9/99	Adelphi,	MD
	21. Signature of Pheral Service Lice			22. Nama and Ad	drass of Facility			
PEC	K:11 (00		Lincoln &	Lincoln	Funeral	Service	
	(lonv. 7	mo			ostia Ave		Wash., D	C 20019
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1. Decedent's Name (F.	First Middle 1 -	etl			ficate of	Dodin	2. Date of Dea	leg. No.	1	3. Time of Death
I. Decedent's Name (F	TISI, MIUUIB, LA						Month	Day	Year	
Mildred	Ressle	r Hieber					January			11:20 pm
4a Facility Name (If no	ot institution, giv	e street and number)				4b. City, Town, or	Location of Death	4c. County	of Death	
Doctors (Communi	ty Hospita	a1			Lanham		Princ	ce Geo	orge's
5. Sociel Security Numb				A.	If Under 1 Year Months Deys			Year)		ce (State or Foreign
167-05-8556	6	□M 2⊠F	84	Yrs.	violitis Doys	Tiodis Wat.	Aug. 5,	1914		sylvania
Usual Residence of De										
10a. State 10	0b. County		10c. Cit	ty, Town or Locat	tion				100	d. Inside City Limits
Maryland I	Prince	George's		Green	helt					1 X Yes 2 No
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120 North	way koa	12. Wes Decedent	Everie II	C 12 Ma	207		accifu Vac or No.	U.S.A	e - America	n Indien
11. Maritel Status		Armed Forces?		IS. Was	es, specify Cut	Hispanic Origin? (S sen, Mexican, Puer	to Rican, etc.)	Blac	k, White, et	
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3 ☐ Widowed 4 ☐	Divorced	Year or Dates:								ite
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12				Home	emaker			Own Ho	ome _	
17. Fether's Name (Firs	st, Middle, Last)					18. Mother's Na	me (First, Middle,	Meiden Sumen	10)	
Samuel H	Ressler					Gert	rude Wi	lson		
19a. Informant's Name.		Type, Print)		19b. Mailing	Address (Street	t and Number or R			State. Zip (Code)
Thomas B. I		- nuspand	20h F	12U NO:		Road, Gr	Date Date	Marylan 20c. Location -		0770 m State
•		Removel from Stete		cemetery, cremat	tory or other pla	ace)	Date	20c. Location -	City of Tow	m, Stete
4 □ Donetion 5 □				eenbelt	City C	emetery !	01/14/99	Greenbe	elt, M	Maryland
21. Signature of FuneA	N Service Goer	1900	1	22. N	lame and Addr	ess of Fecility				
N /	AA X	1. 15	-			meral Ho				
23a Part Enter the d	HWY.	plications that cause one cause on each	704	473	9 Balti	more Ave	nue, Hya	ttsville		20781 Approximete
Immediate Cause (Final disease or condition	al	. Cardio	Rest	oiratory						Interval Batween Onset and Deeth
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended#2 perPhyG768 2/22/99 EW 1. Decedent's Nema (First, Middla, Last) 2. Deta of Death 3. Time of Death De Month 01:42 pm JANUARY 8+,4 1999 BARBARA HOBBS 4c. County of Death 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death GEORGE PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE If Under 1 Ye Birthplace (Stete or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Months Hours 1 M 20 F Days 52 139-36-6133 New Jersey Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 No Yes 2 No Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 935 Balboa Avenue 20743 USA 14. Rece - American Indian, Black, Whita, atc. 12. Wes Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Meritel Stetus 1 ☐ Yas 2 X No If Yes, Give 1 ☐ Navar Married > Married 1 ☐ Yas 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 6 yrs. Nurse Hospital 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Meidan Sumema) Jermiah Pugh Sarah Strafford 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Tyrone V. Hobbs, Husband 935 Balboa Ave., Capitol Hgts., Md. 20 20c. Locetion - City or Town, Stete 20743 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete cemetery, cremetory or other piece) 1 ☐ Burlal 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 1-12-99 Landover, Md. 21. Signatury of Funeral Service Licens 22. Nama and Address of Facility Ralph Williams Funeral Service 517 11th St., S.E., Wash., DC 20003 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart lailure. List only one cause on each line. Approximate Intervel Between Onsat and Deeth Immediete Cause (Finel HYPERTENSIVE ARTERIOSCUEPOTIC CARDIOVASCULAR DISEASE diseese or condition resulting in deeth) Due to (or as a consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es a consequence ol) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of cause ol deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Piece of Injury - At home, ferm, streat, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 ☐ Homicide

/Medical Examiner attending physician and for use es the bunal-transit law requires that the death certificate be executed Records, P.O. Box 68760 signed by the al been si is certificate has t director, page 2 s Division of Vital Hospital or Attending Physician: this funerel After death. by the To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in b

Physician

/Medical

Examiner

Director

Funeral

by

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Certification:

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the Maryland

filed within 72 hours after death with the Marylan Hygiene. other then "natural", or frame 23s or 28s-f show ent, the Moorest Easterner, was be notified as

marked other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if fem 27 is marked oths any injury or other traumatic avent, price.

Physician

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Dey, Year) 2 1999

MARIO

end address of person who co

GOLLE

29e. Certifies

29b. Signatur

30 No

ed cause of deeth (Item 23a) (Type, Print) MO 3001 32. Registrer's Signeture

PIME

HOSPITAL

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner as stated.

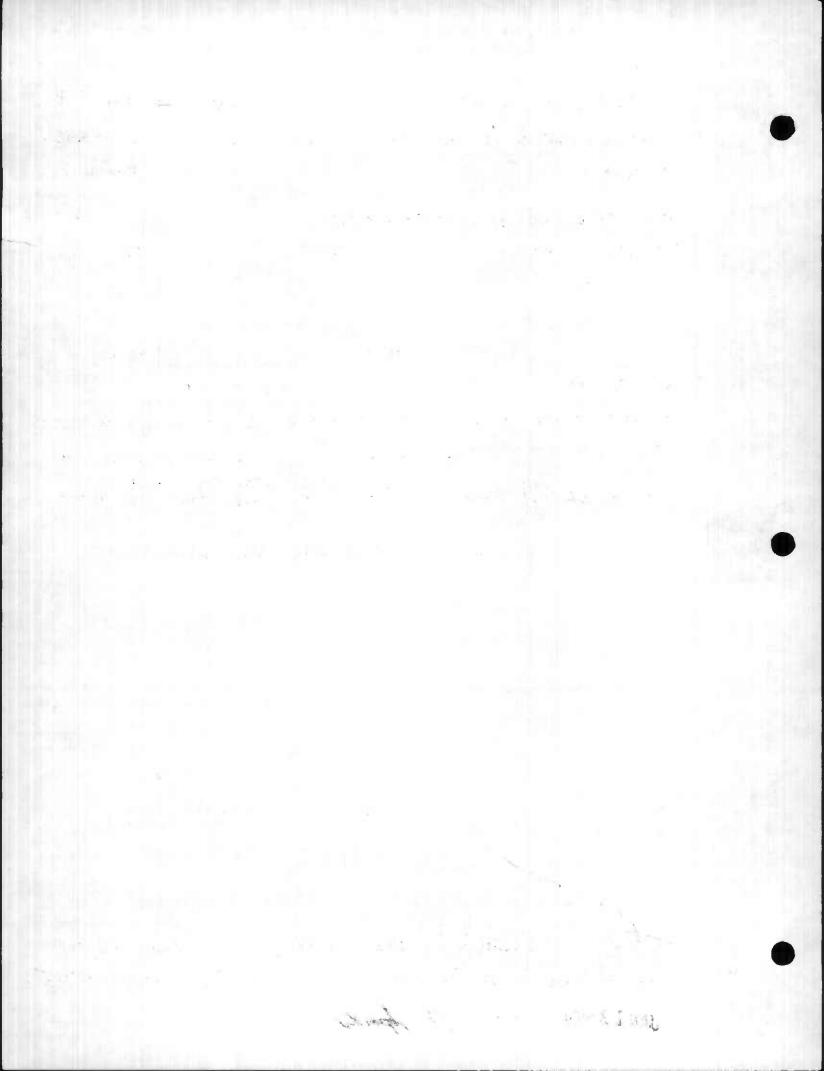
Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end plece, end due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DRIVE, CHEVERLY, MARYLAND 20

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

						rtment ificate					Reg. No.	136		
4	Physician /Medical	Decedent's Neme (First, Middle, I JAMES	ast) HALL						J	2. Dete of D Month ANUARY	Day 7 9,1999	Year	3. Time of 4:45p	
东	Examiner	4a Fecility Neme (If not institution, g	ive street end num	ber)						ation of Dee		ty of Deeth		
		4015 20th PLACE	Cou. 7	Ann IIn um	Inna hijah da ul	If Under 1		TEMPI			1	E GEO		- Ci
	Funeral Director	5. Sociel Security Number 578–18–0934	Sex 7	. Age (in yis.	lest birthdey) Yrs.		Deys	Hours	Min.	8. Date of B (Month, D SEPT.	13,191	9. Birting	olece (Stete or otry) TH CARC	OLINA
B.,		Usuel Residence of Decedent								OLI I.	13,171	, 500.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
1/8	how	10a. Stete 10b. County			ly, Town or Loc							1	0d. Inside Cit	
	the Maryler 28s-1 show notified at	MD PRINCE	GEORGES	TEM	MPLE HII						1		X□ Yes	2 No
	Dire	10e. Street end Number				10f. Zip C					10g. Citizen o			
	ter death w frems 23s free must	4015 20th PLACE	12. Wes Deced	ent Ever in 11	S 112 W		2077		nin? /Sne	nify Yes or N	UNITED	STATI		
Maryland 21215-0020	a o	11. Meritel Stetus 1 Never Merried Merried 3 Widowed 4 Divorced	Armed Ford	es?		Yes, specify		Specify:	, Puerto F	cify Yes or N Rican, etc.)	Spec	eck, White,		
2-0	n 72 hours natural'. ed cal Eu	15. Decedent's			16e. Decede	int's Usuel (Occupe	etion	of working	10	16b. Kind of	Business/In	dustry	
21		(Specify only highest (Elementery/Secondary (0-12)	Coilege (1-	4or 5+)	life. D	O NOT use	retired,)	OI WOINN	·9	0011		T.M.	
121	s 1 and 2 should be filed within thattle and Mental Hygiera. Item 27 is marked other than other traumatic event, the Mental To Be Compi	12			LABORI	£R		19 Matha	da Nomo	(Einst Middle	e, Maiden Sume	ERNME	A.T.	
and	should be filed vand Mental Hygie is marked other turnatic event, trumatic event, even	17. Fether's Neme (First, Middle, La JOHN HALL	51)							AITSHE		iiiie)		
Z	d 2 should be if h and Mental H is marked of traumatic even	19a. Informent's Name/Reletionship	(Type Print)		19b. Mailing	Address (Street e				ber, City or Tow	n. State. Zin	Code)	
Z	od 2 s Ith ar 27 is r trau	CLARENCE CARTER									VILLE,M			
ē,	f Haa fem item	20e. Method of Disposition			Pleca of Dispos	ition (Neme	of			Dete	20c. Location			
SE .	Page ent o nt: If I	Burial 2 Cremetion 3		tate	RYLAND 1			6)	1-	-14-99	LAURE	L,MD		
Baltimore,	permit. Pages 1 end 2 Department of Haalth s Important: if Item 27 is eny Injury or other tra page.	21. Signature of Trunglat Service Lig			22.	Name end	Addres	s of Fecilit	Y.EXA	IDER S	.POPE F	INERAI	HOME	
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A	/Medical Examiner	Immediate Ceuse (Finet disease or condition	.]	NETA	STATA	c w	NO	5 C.	MC	31			2 MO1	V014(
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	cate be executed physician and the burial-transit clical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury		Due to (d	or es a consequ	enca of):						i		
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68		resulting in deeth) Last		Due to (c	or es e consequ	ence oi):								
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<u>e</u>	cata ha									1	Yes 2 No	1	☐ Yes 2 K	No
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Division of Vital Records,	I or Attending after death. Director: After d in by the fune ertification	3 Suicide 6 Could not determine	be 28e. Piaca o	f Injury - At h g, etc. (Specil	ome, ferm, stre- fy)	et, fectory, o	office		2	8f. Location City or T	(Street end Nur own, Stete)	nber or Run	al Route Num	ber,
	To the Hospital or Attending Physician 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification: 7		Physician: To the baminer: On the bes	is of examine)
	To the comp	29b. Signetule end title of certifier	12					number			29d. Date sign			- 11
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	11.4	30. Neme end eddress of person wh												

Registrar

31. Dete tiled (Month, Day, Year)

JAN 1 2 1999

18 1 2 1995 - - - See 3 1 1/48

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 0130 99 CLARENCE HIBBLE JANUARY /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OCEAN CITY 2815 TERN DR. WORCESTER If Undar 1 Year 8. Data of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country)
D. C. 5. Social Sacurity Number 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours Min. 10 M 2□ F SOYrs. 577-07-1727 Usual Residence of Deceden Director permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiena. Introprent, if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, in Medical Event et must be 2002. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD. OCEAN CITY WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21842 U.S.A. 2815 TERN DR. Funeral 12. Wes Decedent Ever in U,S. Amped Forces? 1 Ayes 2 □ No ttyres Give Year or Datas: WW I I Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Merrled 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OF PUBLIC WKS. SANITATION 12 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CLARENCE HIBBLE SR MARION LOUISE DYER 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TERN DR. OCEAN CITY, MD. 21842 JEANETTE HIBBLE 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Deta 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY SALISBURY, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility James F. Burnaide ULLRICH FUNERAL HOME BERLIN, MD. 2181 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsat and Death **Physician** Immediete Cause (Final disease or condition resulting in death) /Medicai **Examiner** Dua to (or as a consequence of) Examiner HF physician end s the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): for use es 98 signed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of causa of death? been si 24a. Was an eutopsy performed? Completed nis certificate has b I director, page 2 sl 1 Yes 2 No 2 No or Attending Physician: 25. Was cese referred to medical examinar? (Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this after death.

Director: After this d in by the funeral d 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 Natural
2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 15 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

, MD

1999

32. Registrer's Signeture

Registrar

State

31. Dete filed (Month, Day, Year)

JAN 12



All the same and the same

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death **Physician** 11:50 PM VIRGINIA F. JOHNSON JANUARY /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 8/24/39 **Funeral** Hours 10M 200 F 231-46-2074 Yrs. 59 Director Charlotte Co, Va Usual Residence of Dacedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. P.G. Chapel Oaks X⊠Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1310 Dunbar Oaks Drive 20743 U.S.A. by Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Yes 2X No Specify: Black Specify: 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade com 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) Seamstress 11th Sewing-Private Industry 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Malden Sumame) 12 should be 1 h and Mental h Walter Lindsey Elsie McCargo 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) them 27 other tra Brenda A. Wilson/Daughter 3717 Donnell Dr., Forestville, Md. 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burlal 2 Cremation 3 Removal from State Ft. Lincoln Cem. Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Servica Licensee 22. Name and Address of Fecility H.S. Washington & Sons Co., Inc. R. Srate 4925 Burroughs Ave., N.E., Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Onset end Deeth **Physician** /Medical Immediata Cause (Final a Obstructive Juandice, Hepatic Enceptulopathy 12-09-98 to disease or condition resulting in death) Examiner Congestive Heart failure
Due to (or as a consequence of): Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting In death) Last Cancer with metastanis to Liver 03-98 to
Due to (or as a consequence of):
01-06-99 Box 68760, Part fl. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. o

by Be Completed

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings available prior to completion of cause of death?

1 Yes 2 No 26. Place of Death (Check only one)

124095

1 ☐ Yes 2 ☐ No

25. Was casa referred to madical axaminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28b. Time of 28d. Describe how injury occurred 5 Pending

1 Natural 2 Accident 1 Yes 2 No investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcida

28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)

Mypertension

15 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. 29b. Signature end title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

Prague B. Patel MD. 5632 Annap-115 Rd # 11 Bladem 56mg

mp. 20710

01-07-99

State Registrar 31. Data filed (Month, Day, Year)

JAN 1 1999

3. Registrar's Signature

DHMH 16 Ray 6/95

Records,

Vital

of

Division

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Certification:

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29a. Certifier

Hospital or Attending Physician: '24 hours after death.
Funeral Director: After this certifica

within 24 hours a To the Funeral D completely filled

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:36 PM **Physician** WALTER BROOKS JOHNSON 0 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3805 Keehar Court Springdale Prince George's If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ₺ M 2 🗆 F Yrs 66 223-38-8569 May 10, 1932 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mentai Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Hygiene. other than "natural", or items 23s or 28s-f show onl, the Modical Examiner must be notified at 1KI Yes 2 No Maryland Prince George's Springdale Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 3805 Keehar Court 20774 U.S.A. Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Black Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b, Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Controller Government 7 is marked other traumatic event, to 18. Mother's Name (First, Middla, Maidan Surname) 17. Father's Name (First, Middle, Last) Be Virginia Lewis Ulysses Johnson 20 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) : If item 27 is 3805 Keehar Court, Springdale, Maryland 20774 Alma Johnson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State permit. Page Department of important: If any injury or once. Hampton, Virginia Hampton Memorial Gardens 1999 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 21. Signeture of Funaral Service Licensee 7474 Landover Road, Landover, Maryland 20785 Venc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each fina. Approximate interval Between the and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Due to (or as a consaquanca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Otsease or injury that initiated events. and Due to (or as a consequence of): the exect physician a s the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) certificate ding ŏ e pe Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? aigned by t 3 Probably 4 Unknown by 24b. Ware autopsy findings eveilable prior to Completed 24e. Was en autopsy performed? completion of cause of death? M frector, page 21 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only ona) Othar: 4 Nursing Home TO Yes No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) # sper of Co. 28a. Data of injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 Natural Accident Attending 5 Pending investigation death 1 Yes 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) or A after Direc 4 Homicide To the Hospital within 24 hours To the Funeral C completely lifed 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signatu 29d_Date/signed (Month, Day, Year)

State Registrar

JAN 1 1

1GGS 2041 Grongle Avc. NW

MEDINE TO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 9 6 0 Certificate of Death

			Certifica	te of Death	Re	g. No.	012	00
Observatoria	1. Decedent'a Neme (First, Middle, La	st)	Description of the		2. Dete of Deeth Month			ma of Death
Physician /Medical	HATTIE M	. JACKSON			JAN. 06		3:0	00 AM
Examiner	4e Facility Name (If not institution, given JOSEPH RITCHIE			BALTIM	ORE CITY	4c. County of C	Death	
Funeral Director	230 40 1103	Fex 7. Age (In yrs. 69	Yrs. If Und Months	er 1 Year If Under 24 Hrs Deys Hours Min		9. 9 SO	Birthplace (Si Country) UTH CAI	
* III	Usual Rasidence of Decedent 10a. Stete 10b. County	10c C	ty, Town or Location				10d Insi	de City Limit
be notified at Director			SHINGTON,				XX	Yes 2 N
		N.W. #222		20001		Og. Citizen of What NITED ST		
Lamber must Lamber must by Funeral	3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give AA Year or Detes:	If Yes, sp	edent of Hispanic Origin? (secify Cuben, Mexican, Puer 2 12 12 13 16 16 17 18 19 19 19 19 19 19 19 19 19 19 19 19 19	Specify Yes or No- rto Rican, etc.)	Bleck, V	American India White, etc. FRO-AMI	
and of	15. Decedent's E. (Specify only highest gra	ducation ide completed)	16a. Decedent's Us	uel Occupation ork done during most of wo	orkina 1	6b. Kind of Busine	ess/Industry	
ther than 'naturn ont, the Madical o Completed	Elementery/Secondary (0-12) 1 OTH	College (1-4or 5+)		rork done during most of wo use retired) mestic		Priv	ate	
9	17. Fether's Neme (First, Middle, Last)		18. Mother's Na	ame (First, Middla, N	faiden Sumama)		
To B				ELEANO	R BRIGGS			
Traum	19e. Informent's Name/Ralationship (HAZEL DODSON -NI			ss (Street and Number or F				2
important: if it any injury or o once.	h⊠Burial 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Special 21. Signature of Funeral Service Lice	1 1 1 0	22. Name	other place) RIAL PARK CEN and Address of Fecility FUNERAL HOM	1. 1-12-99	16.5	VER, MA	RYLAN
/	23a. Pert1. Enter the disease, or com shock, or heart failure. List only	DWARD M. DUDLI	3200 R	CHODE ISLAND	AVE., III.	RAINIER	, MD	
ng physician and s as the buriel-transit Medical Examine	Cause (Disease or Injury that initiated events resulting in death) Last	c	or es a consequence of					
for use		d						
Physic	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	causa given in Part I.	2 4 7 7 7 7	bacco uae contril a 2□ No 3[
ate hes been agged by the attending page 2 should be detected for use Completed by Physician/					24e. Wes ar perform		4b. Wera auto available p completion of death?	
Com Com	STALL AND ADDRESS OF				1□ Ye	s 2 No	1 🗆 Yas	2 No
director, page 2	25 Was case referred to medical				eeth (Check only one	9)		
	1 ☐ Yes 2 No	Hospitel: 1 ☐ Inpatienf 2 ☐	ER/Outpatienf 3□ [Home 5 Reside	nce 6 Other	Specify) Hi	ospice
After	27. Menner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b		28b. Tima of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe ho			
the Funeral Director: The state of the stat		28a. Place of Injury - At h building, etc. (Speci	ome, ferm, street, fectory)	ory, office	City or Town	reet and Number o , Stete)	or Hurel Houte	Number,
Petaly filled in edical Cert		ysician: To the best of my kno niner: On the basis of examine and manner steted.	owiedge, death occurre ation and/or invastigation	d at the time, date end plec on, in my opinion, daath occ	e, end due to the ca curred at tha time, da	use(s) and menne ita and place, and	er as stated. I dua to tha ce	use(s)
2	29b. Signature and title of certifier	^		9c. License number		d. Date signed (A	Aonth, Day, Ye	ear)
0)	30. Name and addrass of person who	completed course of death file		014383	5	1/6/	99	
	Harold C 5	bendiford		Richey 11	espice			
State	31. Data filed (Month, Day, Year)	32. Registrar's Signo						

DHMH 16 Rev 6/95

SAM à 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene NESBITT KEITH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month JAN. Day 999 **Physician** 9. Nesbit Kiett 12:58 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES HOSPITAL CENTER PRINCE GEORGES CHEVERLY If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year)
Dec. 26, 1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign **Funeral** Days M 2DF Months Hours Wash., D.C. 579-72-4113 45 Yrs. Director **Usual Residence of Decedent** the Merylend 10b. County 10a State 10c. City. Town or Location 10d. Inside City Limits Nema 23s or 28s-f show her must be notified at No Yas 2 No Director District of Columbia Washington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4040 E. Capitol St., N.E. #E43 20019 United States deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mentei Hygiene. Important: If Item 27 is marked other than "natural", or Nem eny Injury or other treumatic event, the Heddell Experience 1 Never Married 2 Married 1 Yes 2 No Specify: Black. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Private 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) 8 Pinkey Kiett Zola Riggins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Otelia Kiett - Wife 4040 E. Capitol St., N.E., #E43; Wash., D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Date 1 ABurial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 1/16/99 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 woo 23a. Part. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, show or heart feiture. List only one cause on sech line. Approximata Interval Between Onset and Death **Physician** turoschope castovasalas Disecto Immediata Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physicien end a the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included assets) Due to (or as a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contributs to the cause of death? signed by t 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? hes 1 Yes 2 No 15839es 2□ No. 8 26. Place of Death (Check only ona)

certificate be executed 68760 Box P.0. Records, Division of Vital 2 this After this To the Hospital or Attending Ping 24 hours effer death.
To the Funeral Director: After the completely filled in by the funeral Certification:

Baltimore, Maryland 21215-0020

25. Was case referred to medical examiner? No. Yes 2 □ No. 27. Manner of Death

1 Watural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier (Check only 5 Pending investigation 6 Could not be

Hospital: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 28c. Injury et Work? 1 Yas 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Commonship of the death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) 10, 1999 JAN.

completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

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32. Registrar's Signatura JAN 1 2 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 1999 11, 12:38 PM SHERWOOD JOSEPH LINKINS 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign

parmit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene.
Important: If team 27 is marked other than "natural", or items 23s or 28s-f ahow any Injury or other traumatic avent, the Medical Engine ment be notified as her wood Joseph Linkins

Physician

/Medical

Examiner

Funeral Director

Physicia /Medic Examine

To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

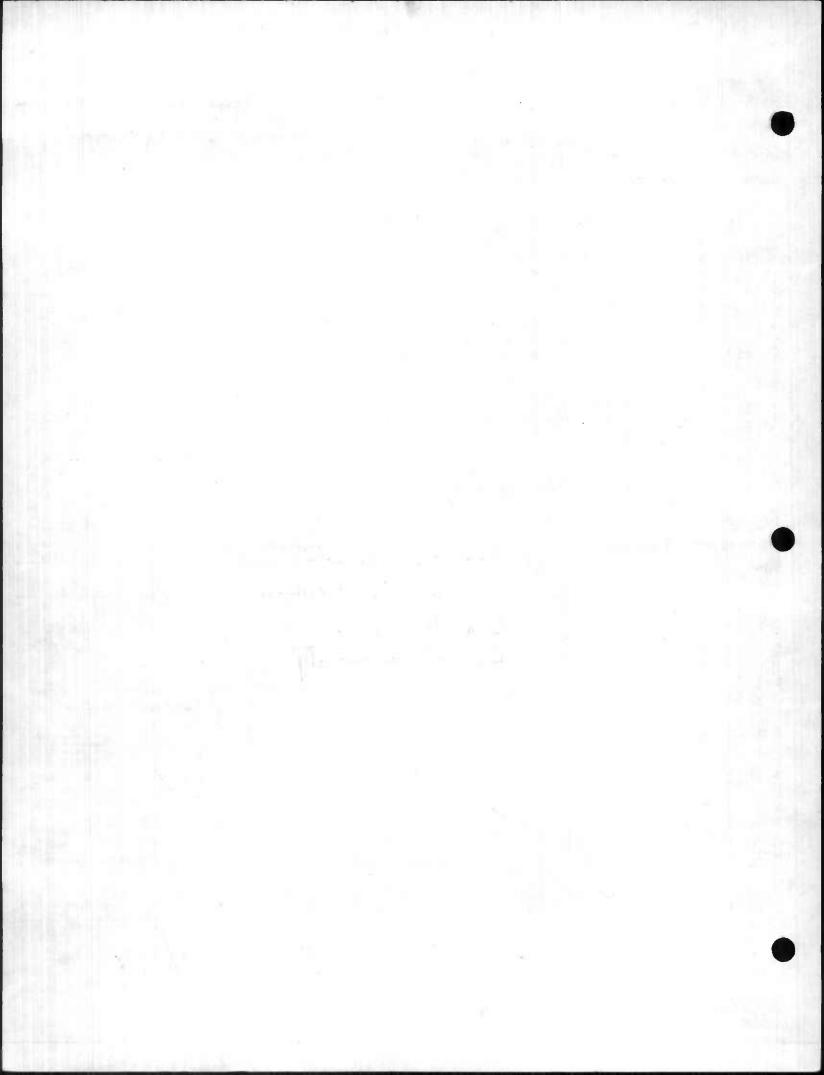
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

once.	
유 프 크 Medical Certification: To Be Completed by Physician/Medical Examiner	

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MARYLAND PRINCE GEORGE FORT WASHINGT 10a. Street and Number 10d. 6801 BOCK ROAD APT. #231 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forças? If Yes, 1 1 Yes, Give Year or Dates: 1 Never Married 2 Married Never Mar
MARY LAND PRINCE GEORGE FORT WASHING
6801 BOCK ROAD APT. #231 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced Divorced Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)
11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was De if Yes, 1 1 Yes 2 No 1 Yes 2 No 1 Yes 1 Yes
Armed Forças? 1 Never Married 2 Married 3 Widowed 4 Divorced Pear or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+)
(Specify only highest grade completed) [Give kind o life. DO NC [Give kind o life. DO NC
Elementery/Secondary (0-12) College (1-4or 5+)
17. Father's Name (First, Middle, Last)
CHARLIE GASKINS
19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Ad 1)
DELORES G. LINKINS / WIFE 6801 BOX 20744
20a. Method of Disposition 20b. Place of Disposition cemetery, cremator
1 \(\text{Secrited} \) 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) 4 \(\text{Donation} \) 5 \(\text{Other} \) (Specify) \(\text{ST. CHARLE} \) ST. CHARLE
21. Suprillure of Funeral Service Lineause 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
C. THO NT N JOHNSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death
Immediate Cause (Final D /
disease or condition resulting in death) a. The monary Conflict b. The monary Conflict a. The monary Conflict b. The monary Conflict conf
Due to (or as Leonsequence of):
6. Freetine Kylutarkle.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury
cause. Enter Underlying Ceuse (Disease or injury c. Disable to type I
that initiated events resulting in death) Last Due to (or as a connequence of):
d Cialien heusspally
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?
1 Yes 2 No 3 Probably 4 Unknown
DAN West states for first
24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
of death?
1 Yes 2 1 No 1 Yes 2 No
25. Was case released to medicai 26. Place of Deeth (Check only one)
examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1. Dending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Describe how injury occurred Work?
M I Ves 2 DNe
2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number,
2 Accident investigation M 1 Yes 2 No
2 Accident 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office 29e. Certifier 29a. Certifier 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 29a. Certifier 29a. Certifier
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2 Accident 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office 29a. Certifier (Check only 2 Medical Examines: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)
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2 Accident 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and It of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)
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2 Accident 3 Suicide 4 Homicide 28e. Plece of Injury - At home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and filts of certifier 29b. Signature and filts of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

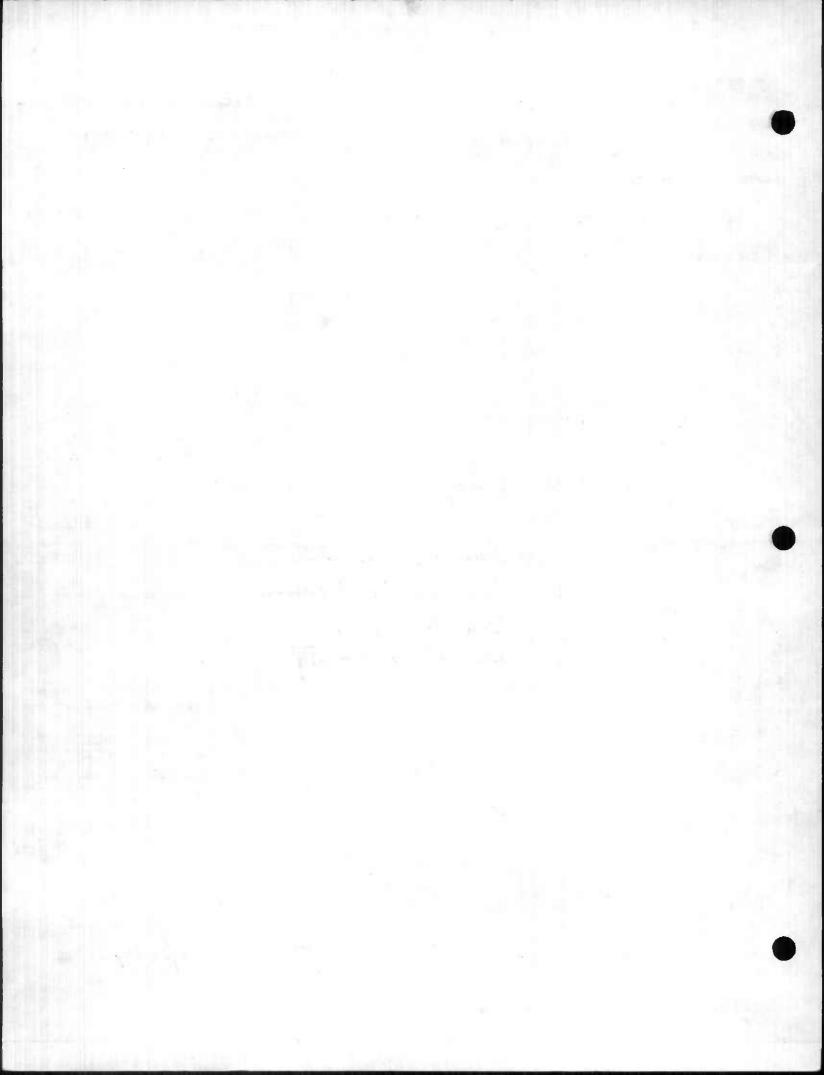
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	U	sual Residence o	of Decedent			140-0									
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5	6	801 BOCE		дрт	#231			101. 21	p Code	20744			10g. Citizen		
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2			15. Deceden	t's Educa	ation		16a. Deced	dent's Usu	el Occur	ation			16b. Kind o	Business/in	
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	_	DELORES (Da. Method of Dis		INS	/ WIFE		Place of Dispo) APT	. 23.	Date Date	20c. Locatio		MD 20744
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State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death **Physician** Lawrence A. Lacey jan 5,1999 01:20am /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery Hours Min. 8. Data of Birth (Month, Day, Yeer) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar **Funeral** 1 X M 2 □ F Days 579-18-0957 78 August 17,1920 Washington,DC Director Usual Residence of Decedant the Maryland 10a Stata 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macical Examinar must be notified at 10d. Insida City Limits 1 Yas 2 □ No Maryland Prince George's Beltsville Direct 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? With 3604 Shenandoah Drive 20705 U.S.A. Funeral death 11 Marital Status 12. Was Decedant Evar In U,S. Armed Forcas? Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. Peges 1 and 2 should be filed within 72 hours after one of Health and Mentel Hygiene. Int: If Item 27 Is marked other than "natural", or ite 1 Navar Marriad 2 Married 1 X Yas 2 No If Yes, Giva Year or Detes: Baltimore, Maryland 21215-0020 Black 1 ☐ Yas 2 ☒ No Specify: À 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation

Whind of work dona during most of working Completed 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry (Give kind of work dona du life. DO NOT usa ratired) Collega (1-4or 5+) 2 years Elemantary/Secondary (0-12) Laborer Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) James Youngblood Mary (Unknown) 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) Mary E. Wooten-Lacey/Wife 3604 Shenandoah Drive, Beltsville, Maryland 20705 other 1 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 01/09 0 1 X Burial 2 Cramation 3 Ramoval from State Department of important: If any injury or Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 1999 22. Name and Address of Facility
B. JENKINS FUNERAL HOME 21. Signatura of Funaral Sarvice Licenses Non Ver cer 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediete Ceuse (Final diseasa or condition rasulting in death) Examiner Examiner the death certificete be executed bunel-transit Saquantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last pue physician e Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): for ed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen hes Kinsonis certificete 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: after death. Diractor: After this certific funeral director, 25. Was cesa rafarrad to medical axaminar? 26. Place of Deeth (Check only ona) Hospital: 1 Yas 20 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Impatiant 2 ☐ ER/Outpetiant 3 ☐ DOA 28a. Deta of Injury (Month, Day Yaar) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Invastigation 1-Natural 1 Tyes 2 □ No 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 Homicida 24 hours a Funeral D Certifying Physician: To tha best of my knowledga, daath occurred at the tima, data and place, and due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. edical 29a. Cartifier pletely (Check only one) To the To the To the I 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) d cause of death (Hem 23e) (Type, Print) 32 Ragistrar's Signature Registrar

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 6 is

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 07 **Physician** GLADYS ELIZABETH LITTLETON 9:27 PM 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 X F 216-22-0680 78 Director 5, 1920 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 X Yas 2 □ No Director Maryland Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11508 Polaris Drive 20774 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Stalus 12. Was Decedent Ever in U,S. Armed Forces? permit. Pegas 1 and 2 should be filed within 72 hours effer. Depertment of Hasith and Mental hygiene. Important: if item 27 is marked other than "natural; or Nan eny injury or other traumatic event, the Medical Examination." 1 Never Married 2 Merried 1 Yes 2 No
If Yes, Give
Year or Dates: Baltlmore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 ☒ No Specify: by 3 ☑ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Government 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Estelle Stewart Harrison Hall 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Littleton/Son 11508 Polaris Drive, Upper Marlboro, MD 20774 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 01713 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 1999 Landover, Maryland 22. Name and Address of Facility
J.B. JENKINS FUNERAL HOME 21. Signature of Funerel Service Licensee Nan 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and a the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequ attending for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? aigned by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wera autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 s 20 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manyler of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and filling certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 7700 Old Branch Ave, #101, Clinton, MD 20735 Laxmi Berwna, 32. Registrer's Signatur 1 1999 State Registrar

DHMH 16 Rev 6/95

JAN 1 1999 Services

Examiner The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: death. To the Hospital within 24 hours a Volume of To the Funeral Completely filled

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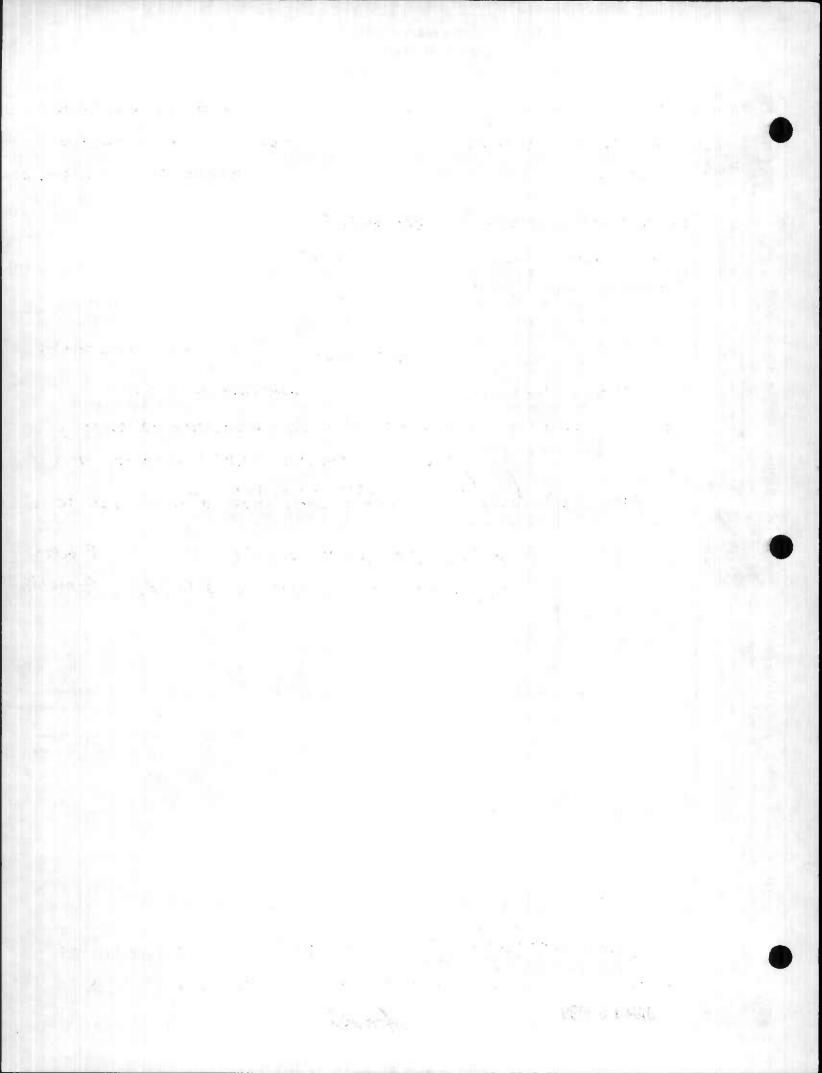
January 14, 1999

State Registrar 9470 Annapolis Road, Suite #308, Lanham, Maryland 32. Registrer's Signeture rece once boald

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Hema Yadla, M.D.,

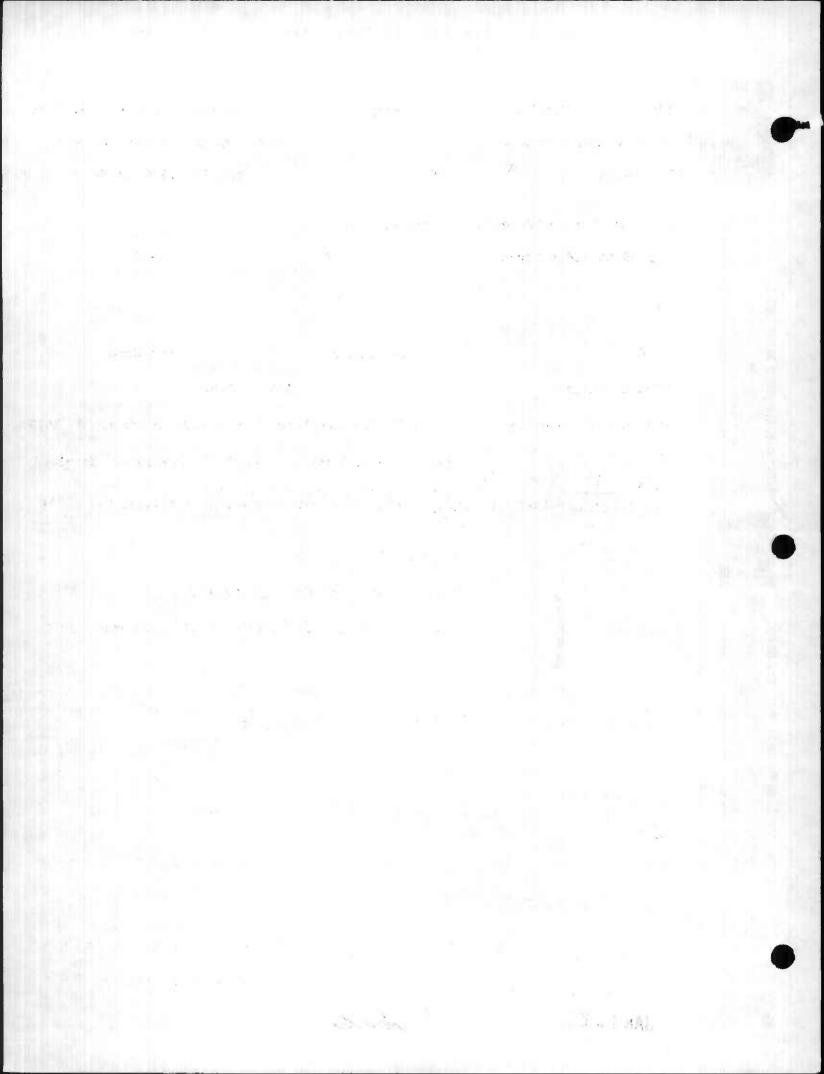
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DHMH 16 Rev 6/95



100 Aftar

Box 68760. P.O. Records, Division of Vitai 8 Certification: To Attanding

Baitimore, Maryland 21215-0020

To the Hospital or Attanding within 24 hours effer death.
To the Funeral Director: Afti completely filled in by the fun

State Registrar

28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Hospital: 1 npatient 2 ER/Outpatient 3 DOA

11. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 29c. License number 1.11.99 D46478

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Piece of Deeth (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7501 SurrattsRd # 307 clinton mp 20735 Suresh A. Patelmo

31. Dale filed (Month, Day, Year) JAN 1 3 1999

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 De atural

2 Accident

3 ☐ Suicide

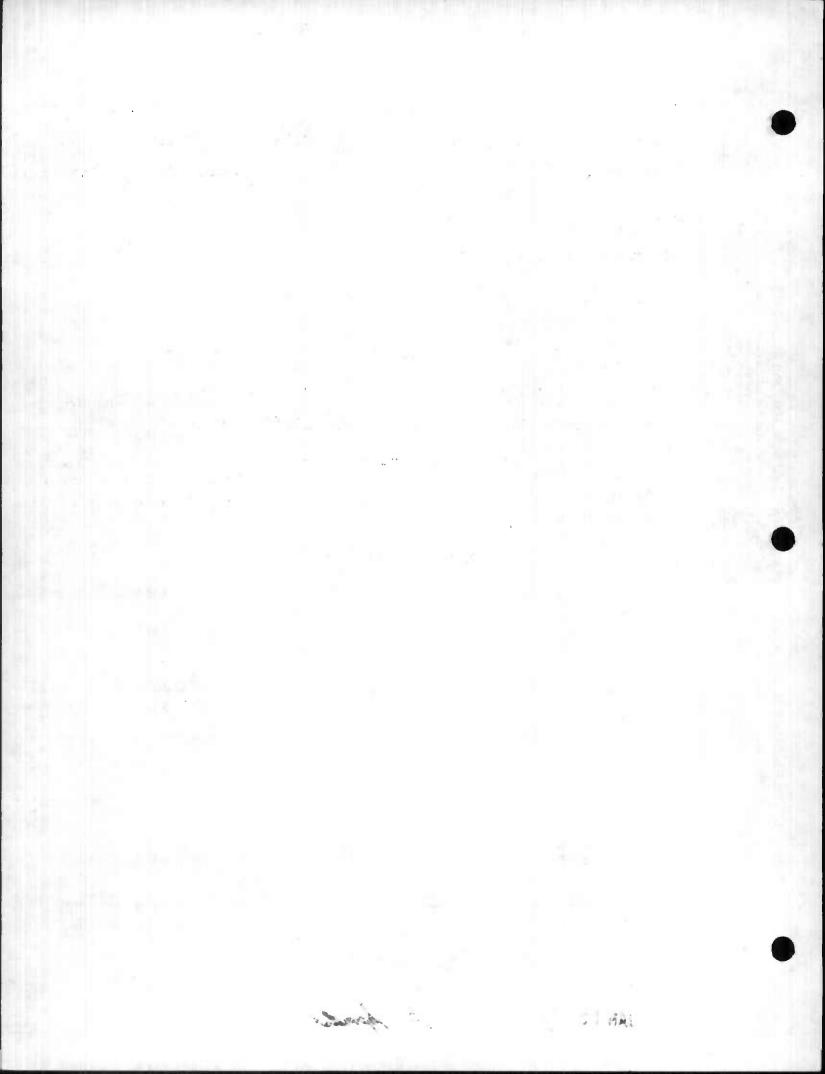
29a. Certifier (Check only one)

4 Homicide

32. Registrar's Signature 1. 200 2 Another

28c. Injury et Work?

1 Yes 2 No



	Plea	ase Type or	Print in	Black In	delible	e Ink	. Assu	ıre A	II Copies	Are Le	glble.	1968
		State	of Maryla	and / Dep			Health a Death		lental Hy	giene		
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4e. Fecility Neme (n, give street end n	A. Lac	henmay	er		4b. City, To Oxon		ocation of Deat	h 4c. Cour	nty of Deatl	
5. Social Security N 579–52–76		6. Sex 1 M 2 ☐ F	7. Age (In yi	rs. last birthdey, Yrs.	Months Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, Da Oct. 7	th ry, Year)	Co	hplece (State or Foreign winty) Kfurt, Ger.
Usuel Residence of 10e. Stete Maryland	10b. County	George's		City, Town or Lo Oxon Hi								10d. Inside City Limits 1 ☐ Yes ♣☐ No
912 Whit		Dr.			10f. Zip	Code 0745				10g. Citizen o		intry?
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21. Signature of Fu	rege	fKai	al	6	eorge 160 (e P. Oxon	Hill	s Fun Rd.	neral H Oxon H	ill, M	.A. D 207	45
		r complications that tonly one cause on	caused the de eech line.	eth. Do not en	ter the mod	de of dyi	ng, such es	cardiec	or respiretory e	rrest,		Approximete Interval Between Onset and Death
Immediate Cause disease or condition resulting in deeth)	(Finel on	a•M		(or es a conse			cara	noma	of the !	sladder		11 musths
Sequentially list co if eny, leading to in cause. Enter Under Cause (Disease or	enditions, nmediete erlying	b. ———	Due to	(or es a conse	quence of):							
Cause (Disease or thet initieted events resulting in deeth)	8	c	Due to	(or as e consec	quence of):							

Physician /Medical Examiner

> the attending physicien end hed for use es the burial-transit detached for filled in by the funeral director,

After this certificate has

To the Hospital or Attanding Physician: within 24 hours after deeth.

The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be 2 Certification:

Sequentielly list conditions if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last

Director

Funeral

à

Completed

Be To

Physician /Medical

Examiner

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Meryland Department of Heelth and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Events.

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1□ Yes 2☑No

1 Yes 2 No

exeminer?					20	. Fiece of Deetil	[Crieck Orlly Orle)	
1 Yes 2 1	No	Hospitel: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 🗆 1	DOA Other:	4 Nursing Hon	ne 5 Residence	6 □Other (Specify)
27. Menner of Deeth 1 ☑ Netural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury et Work? 1 \(\text{Yes}	2	8d. Describe how inj	ury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Plece of Injury - Al building, etc. (Spe	home, ferm, stree	of, fect	ory, office	2	8f. Location (Street e City or Town, Ste	end Number or Rural Route Number, ete)

29e. Certifier (Check only one)

25. Was case referred to medical

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as ststed.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of cartifier

1 2 1999

4301062644

29c. License number MICHIGAN

29d. Date signed (Month, Dey, Year) 1/11/99

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

1050 West Perimeter Road, Suite BBSD, Andrews AFB, 41) 20762-6600 Kenneth L. Abbott MI) 31. Dete filed (Month, Dey, Year)

State Registrar

Medicai

32. Registrer's Signature

Control of the second of the s

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Lewis Katie 1999 Jan 8 1035 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** montsomers Cross Silver Spilna HOSPITAL 14014 8. Date of Birth Month, Day, Year, FEB. 14,1926 If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Months Days Hours GEORGIA 72 257-78-4048 Yes. Director **Uauel Residenca of Decedent** 3 1/2 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits TO Yes 2 No Director SILVER SPRING MONTGOMERY 280-7 MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 20902 UNITED STATES 2303 EVANS DR. Nerns 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0020 8 1 Yes 2 No Specify p 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEKEEPER permit. Pages 1 and 2 ahould be file.
Department of Health and Montal Hy,
Important: if Item 27 is master
any injury or 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES FOSTER DONNIE GRIGG 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2303 EVANS DR. SILVER SPRING, MD 20902 19a. Informant's Neme/Relationahip (Type, Print) JAMES LEWIS / SON 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Denial 2 Cramation 3 Removel from Stete GATE OF HEAVEN CEMETERY 1-13-99 SILVER SPRING, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility LEXANDER S. POPE FUNERAL HOME 21. Signature of Funerel Service Licenses 5538 MARLBORO PIKE FORESTVILLE, MD 20747 17108 23a. Perf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximeta Intarvel Between Onset and Death Physician /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of) Physician/Medical Examiner en9100 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated avants resulting in death) Last burial-trar Due to (or as a cor P.O. Box 68760. 0 the Dua to (or as a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 3 No 3 Probably 4 Unknown should be det Records, by 24b. Wara eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? pege 2 : 2 No 1 □ Yes 2 □ No Division of Vital funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No investigetion 2 Accidant 6 Could not be 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannan stated. 29a. Certifier

State Registrar

29b. Sig

31. Date filed (Month, Day, Year)

JAN 1 2 1999

ature and title of certified

N. BRECHER, MO DME 82. Registrar's Signature

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Cer is DMG

Sriver Spring,

29c. License number

1000458

2101 merical Park

29d. Date signed (Month, Day, Year)

2001 3 1 MAL

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** Frederic Christian Mahler January 6, 1999 12:42 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Hours 12 M 2 F Vis 201-22-3999 69 Director September 19,1929 New Jersey Usual Rasidance of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo 28a-f Prince George's Maryland College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 20740 (#818)United States Funeral Park Drive 6200 Westchester 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status Armed Porcess
1 Si Yes 2 No
If Yes, Give
Year or Dates: 5 / 5 3-5 / 55 hours after 1 Nevar Married 2 Merried 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Rusiness/Industry filed within Elementery/Secondary (0-12) College (1-4or 5+) 12 4 Salesman Sales 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be the Department of Health and Mental H Important: If them 27 is marked oth any Injury or other traumatic even Be 2 Frederic C. Mahler Edith Bryson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20740 19a. Informant's Name/Raletionship (Type, Print) 6200 Westchester Park Drive (#818), College Park, Md. Katherine K. Mahler-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 1-12-99 Cheltenham, Maryland 21. Signature of Funeral Service Ligens 22, Name and Address of Facility Fort Lincoln Funeral Home 3401Bladensburg Rd., Brentwood, Maryland 20722 23a. Per I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Physician /Medical Immediata Causa (Final 12 hours diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any, laeding to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last the burlai-tran Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): 88 980 Part II. Other significant conditions contributing to death but not requiring in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 0 been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown 9 py Records, Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Vital Attending Physician: director Be 25. Was casa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Certification: To Division of this 28a. Data of Injury (Month, Day Year) funeral Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending invastigation s after deeth. 1 Yes 2 No 6 Could not be datermined 3 Suicida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide filled in 6 24 hours a Hospital DECERTIFYING Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medical completely (Check only one) Within 2 94 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 34032 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person - AVE KENSINGTON 3720 31. Data filed (Month, Day, Year) 22. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

JAN 1 1 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/Medical		acility Name (If not institution, giv		VEH		4b. City, Town, or Lo	JANUAP ocation of Death		1-1-1
Examiner			to SPITA	L CE	NTER	BALT			
uneral				(In yrs. lest birth	dey) If Under 1 Year	if Under 24 Hrs.	8. Date of Birt (Month, Da		9. Birthplace (State or Fo
rector	23	33-24-1311	1 X M 2 □ F	82 Y	rs. Months Days	Hours Min.	11/29/	16	Gaston Co.
		Residence of Decedent							1404 1-14-0% I
ahow adm	10a. S			10c. City, Town					10d. inside City L
23s or 28s-f sho ust be notified at rai Director	141	d. Prince Geo	orge's	Croft					
Dire	10e. S	Street and Number	n Dona		10f. Zip Code			10g. Citizen of W	
rai i		2648 Evergreen		1.110	21113			U.S.A	A American Indian,
al, or teams 23s or 28s-1s. rentied reast be notified by Funeral Director	11. M	larital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of If Yes, specify Cut	pan, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.
y F	3	□ Never Merried 2 Married □ Widowed 4 □ Divorced	1 Yes 2 No if Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	Black
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omp	Ele	ementary/Secondary (0-12) 5th	College (1-4or 5+		chool Bus D	river		Transpo	rtation
event, Be Co	17. F	ether's Name (First, Middle, Last)			18. Mother's Nem-	e (First, Middle,		
ie marked of sumatic eve To Be	,	Samuel McVe	ea			Mary	Rankins		
umer I		Informant's Neme/Reletionship (Type, Print)	19b.	Mailing Address (Stree	and Number or Rur	al Route Numb	er, City or Town, S	State, Zip Code)
27 is or trau	S	Samuel McVea/Sor	1	37	16 Brooklyn	Ave.,Bal	t.,Md.	21225	
If item 27 is marked other than or other traumatic event, the M TO Be Comp	-	Method of Disposition		20b. Plece of cemetery	Disposition (Name of , crematory or other ple	ece)	Date	20c. Location - 0	City or Town, Stete
7. T. P.		t ☐ Burial 2 ☐ Cremetion 3 ☐ ☐ Donation 5 ☐ Other (Special			olis Mem. (/18/99	Annapol	lis, Md.
Important: If item 2 any injury or other pnce.	21. 5	Signature of Funeral Service Lice	nsee	1	22. Name and Addr	ess of Facility			
any ir	1	Vanue de	: Grate	_	4925 Burn	shington & coughs Ave	Sons C	Wash.D.	.C. 20019
1000	23a.	Pert1. Enter the divese, or com shock, or heart failure. List only	plications that caused !	the deeth. Do no					Approximate Interval Between
) physician and its the burial-trensit edical Examiner	Sequif eny caus Caus thet i resul	uentially list conditions, y, leeding to immediate e. Enter Underlying se (Diseese or injury initiated events iting in death) Last	Lyn	Oue to (or as a co	onsequenca of):				
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	Part	i. Other significant conditions		t not resulting in	the underlying cause g	iven In Part I.	23b. Did	tobacco use con	itribute to the ceues of c
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has been signed by the attending je 2 should be deteched for use a mpleted by Physician/Me	Parti	Chronic od	contributing to death but	e Pyl		1-	1 🗆	Yee 2□ No en eutopsy ormed?	3 Probably 4 Un 24b. Were autopsy find aveilable prior to completion of cau
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cerificate has been signed by tha attanding irector, page 2 should be detached for use a rector, page 2 should be detached for use as BE Completed by Physician/Me	Part II	Chronic od	contributing to death but	e Bylo	momenty	26. Place of Deal	24a. Was perfo	Yes 2 No en eutopsy med? Yes 2 No	24b. Were autopsy find aveilable prior to completion of cau of death? 1 Yes 2 No.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month 19990827A MUARY Ruby Faye Midkiff /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY OF MANYLAND MEdicinE Baltimurz Baltimore City 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Dey, Yeer) 5. Social Security Number Birthplaca (State or Foreign Country) **Funerai** Days 1 □ M 2 🖾 F 79 Director 220-34-8287 Oct. 12, 1919 Virginia Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 X Yes 2 No Directo Maryland Prince George's Bladensburg 10e. Street and Number 10g Citizen of What Country? 5013 Townsend Way, Apt. B-1 20710 U.S.A. Funeral 12. Was Dacedant Ever In U,S. Armed Forces? 14. Race - Americen Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Never Marriad 2 Married 1 ☐ Yas 2 No If Yes, Give Year or Dates: 1 Tes 2 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed Pages 1 end 2 should be filed within 72 honent of Health end Mental Hygiene.
int: If Itam 27 is marked other than "naturary or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) James Russell Vechery - Friend 5013 Townsend Way, #B-1, Bladensburg, MD 20710 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If i any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 01/15/99 Brentwood, Maryland Fort Lincoln Cemetery 22. Name and Address of Facility 4 Gasch's Funeral Home, P.A. oroll 4739 Baltimore Avenue, Hyattsville, MD 20781 or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, if only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final End-Stage reval

Due to (or as a consequence of): disaasa or condition resulting in death) Y25. Examiner Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Cerebro vascular accedent Infected asseria venous fistula Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy parformed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitai: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 2 Naturai 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Routa Number, City or Town, Stete) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) · cfrelita, res Jan 13. 1999. D34974

Baltimore, Maryland 21215-0020

Box 68760.

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Records,

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After

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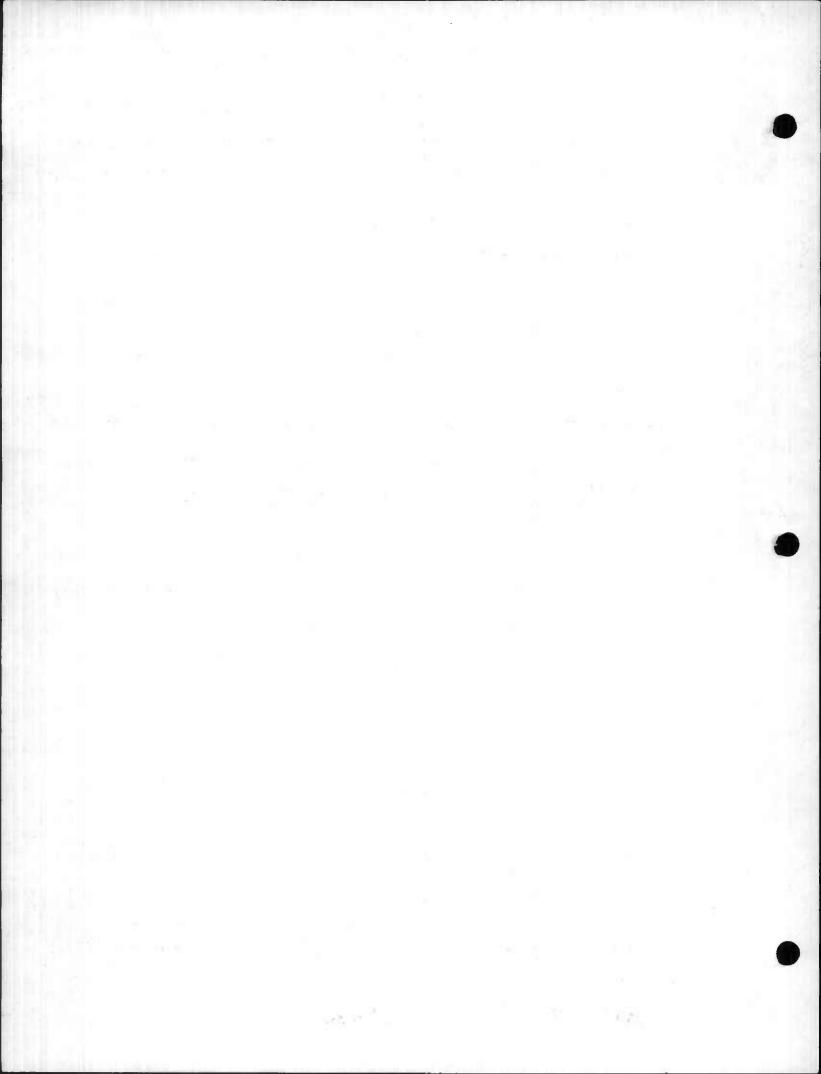
24 hours e

31. Date filed (Month, Dey, Yeer) State Registrar JAN 1 5 1999

CHARUMEHTA, MD, 8775 cloudleap ct. # 224, columbia, MD 21045 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95



Please Type or Print in Black indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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29d. Data signed (Month, Day, Year)

January 09, 1999

	Physician
	/Medical
×	Examiner

ician and burial-transit physician s the burial USB signed by the a The law requires page 2 s director. this After Attanding death. after death Director: filled in by 5 24 hours a Hospital

5. Social Security Number **Funeral** 577-70-9107 Director Usuai Rasidence of Decedent 10a. State 10b. County show Directo 28a-f 10e. Sireel and Number ò 238 Funeral 11. Marital Status 72 hours after 21215-0020 8 þ Completed Elementary/Secondary (0-12) 11th Baltimore, Maryland . Pages 1 and 2 abouid be in ment of Health and Mental H sant. If Item 27 is marked off jury or other traumatic even Be 20a. Method of Disposition permit. Page Department of Important: If any injury or Noncur **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Box 68760, Physician/Medical P.O. Records, py Completed of Vital Be 1 Yes 2 No Certification: To 27. Menner of Death Division 1 Neturel 2 Accident 3 Suicida 4 ☐ Homicide

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year WHITNEY IVAN MORGAN, II January 08, 1999 3:25 P.M. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 120 M 2□ F 47 November 17,1951 Washington, D.C. 10c. City, Town or Location 10d. Inside City Limits 1ØYes 2 No Maryland | Prince George's Landover 10f. Zip Code 10g. Citizen of What Country? 7430 Landover Road 20785 U.S.A. Apt #B 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give 1½ Nevar Marriad 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Datas: **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Painter Private 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Whitney Ivan Morgan Estelle Franklin 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6505 Landover Road, #T-2, Cheverly, Maryland 20785 Antoinette Williams/Daughter 20b. Piece of Disposition (Name of cemetery, crematory or other place) Date 01/14 20c. Location - City or Town, Stata Burial 2 Cremation 3 Removal from State Harmony Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland 1999 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME Percen 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Between Onset and Death With ta 2 Due to (or use consequence of): Due to (or es a consequence of): Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 No 2 No 1 KYes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1.8.99 Soul Tell from porch 281. Location (Street and Number or Rural Route Number, City or Town, State) ell from ONK 1 Yes: 2 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State)

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Vithin 2

DHMH 16 Ray 6/95

State Registrar

Medical

31. Date filed (Month, Day, JAN 1 4 1999

30. Name an

29a. Certifier

(Check only one)

29b. Signatura and title of certifier

dress of pe

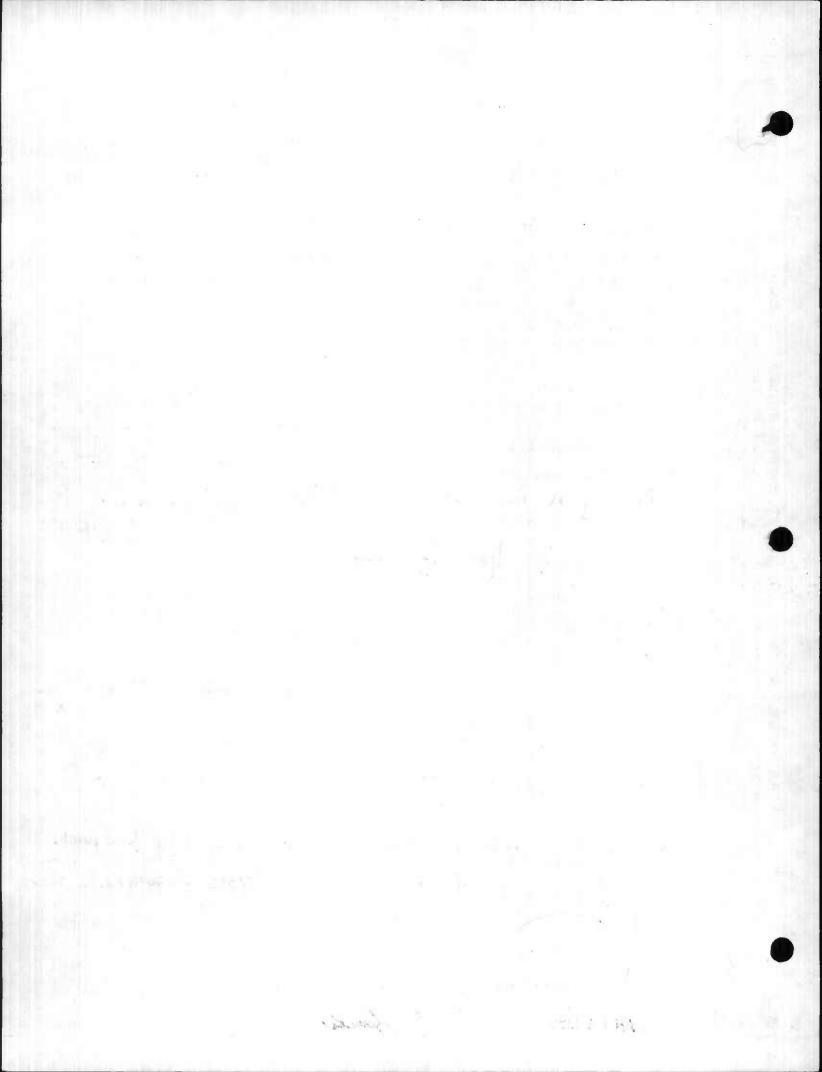
32. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Daath 3. Tima of Death Month Day **Physician** January 3, SYLVIA M. MASON 1999 1:10 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6305 Riggs Road, #304 Hyattsville Prince Georges If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Oct. 26, 1 5. Social Security Number If Undar 1 Yaar 6 Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Jamaica, **Funeral** Days 1□ M 2GF 220-02-2028 70 Yrs. 1928 Director West Indies Usual Rasidance of Decedent permit. Pages 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or terms 23a cv. ??... any injury or other traumatic event. In a second content of the content traumatic event. 10d. Inside City Limits 10a State 10b Counts 10c. City. Town or Location 1 Ves 2 No Director MD PG Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 20783 6305 Riggs Road, #304 Jamaica, West Indies Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas ≥ ZÃNo If Yas, Giva Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Navar Married 2 □ Married Specify: Jamaican 1 ☐ Yas 2 No Specify: P 3 X Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) 3 yrs. Nurse N.I.H. 18. Mother's Nama (First, Middle, Maidan Surnama) 17. Fathar's Nama (First, Middla, Last) Be Emmeline Bailey P Robert C. Evans 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Raiationship (Type, Print) Joan Mason-Smith - Daughter 45 Park Ave. #46, Bloomfield, New Jersey 07003 20b. Place of Disposition (Nama of cematary, crametory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 1-10-99 Adelphi, Maryland George Washington Cem. 21. Signatura of Funaral Sarvice Licansea 22 Nama and Address of Eacility Marshall's Funeral Home, Inc. 0 11/00 4217 9th Street N.W. Washington DC 20011 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediata Ceuse (Final Wedter Myocardial Infarction disease or condition rasulting in death) Examine Dua to (or as a consequence of). Examiner that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, laading to Immadiata cause. Enter Underlying Causa (Disease or Injury that initieted events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) ettending pl signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably W Unknown p The law requires 24b. Were autopsy findings available prior to completion of ceusa of death? been si 24a. Was an autopsy Completed performed? s certificate has I 1 Tyas 2 XNo 1 ☐ Yas 2 ☐ No or Attending Physician: director, Be 25. Was cesa raferred to medical examiner? 26. Placa of Daath (Check only ona) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Panding 1 Naturei 1 Yes 2 No death. investigation Director: / 2 Accident 6 Could not be detarmined 28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Stete) To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b 4 Homicide 29e. Cartifier (Check only one) 1 🔀 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end menner es stated. ed cal 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura end title of certifie 29c. Licansa number January 12, 1999 D20129 30. Nema and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) 7610 Carroll Ave. #390, Takoma Park, MD A. A. Chacko, M.D.

State Registrar

31. Data filed (Month, Day, Yaar)

JAN 1 4 1999

38. Registrar's Signatura

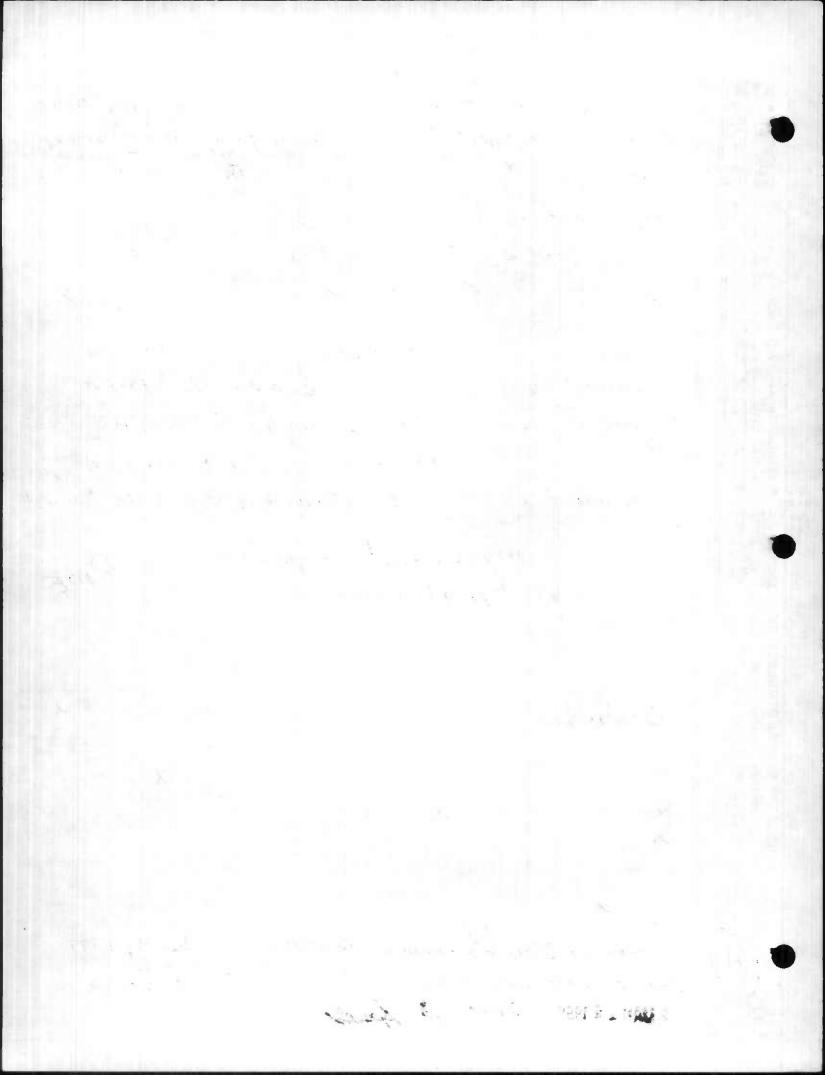
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Physician /Medical	Decedent's Name (First, Middle, Last)	•			
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Examiner Funeral Director	4a Facility Name (If not institution, give street and not be been been been been been been been	pital	der 1 Year If Undar 24 Hrs s Days Hours Min.	pring m.	ounty of Death onto mery 9. Birthplaca (Steta or Foraign Country) NIGERIA
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1 and 2 s Health er am 27 is ther trau	.19a. Informent's Name/Relationship (Type, Print) Bob Martins 50% 20e. Method of Disposition		BunnallE Name of	y CT. Ralei	1 110 27/12
permit. Peges Department of Important: If its any injury or o	1 Definial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funeral Sarvica Licensae	Family Cem.	end Address of Fecility		os Nigeria 3447 14 5+ N.W. NASh., D.C. 200
Physician /Medical Examiner cate Examiner cate Examiner colical Examiner colical Examiner colical Examiner colical Examiner colical Examiner colical Examiner categories of the control of	Immediate Ceuse (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	Due to (or as a consequence of	on):	trom	Onset end Death
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aw requisite should be sho				24e. Wes en eutops: performed?	completion of cause of deeth?
certific rector rector	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2XER/Outpatient 3	Other:	ath (Check only one) Home 5 ☐ Residence 6	
To the Hospital or Attending Physical in Education: The Funantial Director: After this completaly filled in by the funantial direction: To Medical Certification: To	27. Menner of Deeth 1 Naturel 5 Pending Investigation 2 Accident 3 Suicide 6 Columnia de determinate	of Injury and Injury M and Injury - At home, farm, street, fecting, etc. (Specify)	28c. Injury at work? 1 Yes 2 No	28d. Describe how Injury	
he Hospital on in 24 hours affine 24 hours affine Funeral Dipletaly filled in edical Cer	29a. Certifier (Check only Medical Examiner: On the	e best of my knowledge, death occurr basis of examination end/or investigat	ed at the time, date and plec on, in my opinion, deeth occ	e, end due to the cause(s) e urred at the time, date and p	and menner es stated. placa, and due to the cause(s)
To the	29b. Signature and title of certifier	Levm ome	29c. License number	Jan	signed (Month, Dey, Year)
/ //		use of deeth (Item 23a) (Type, Print)	1		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Sallie Elizabeth McMillan 1999 January 9:40AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. Hours Min. If Under 1 Year 7. Age (in yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) Months Deys 1□M 20 F 709-12-4600 Yrs. 96 16, 1902 South Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limita District of Columbia 1 Yes 2 No Washington 10e. Street and Number 10f Zin Code 10g Citizen of What Country? 1558 - 41st Street, S.E. 20020 United States 12. Was Decedent Ever in U.S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ②No if Yea, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Warren Allen Malachi Channie Thomas 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Dorothy Mack - Daughter 1558 - 41st Street, S.E. Washington, D.C. 20020 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 € Burial 2 Cremetion 3 Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Memorial Cem. 1/15/99 Suitland, MD 22. Name end Address of Facility 21. Siggeture of Funeral Service Licen Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 23e. Part7. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BONTE Subendo cordial Ingocardice Inforction Due to (or as a consequence of): Atherosdorate cononary heart disease Years Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted eventa resulting in death) Lest Due to (or es a consequence of): Due to (or as e consequence of): A Cate due to days deus Sepsis, Gran & occi Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown malfi Infanction Demontia with Eult sided 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Distates mollates 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? disoner ulas 26. Place of Deeth (Check only one) Hospitel: 12 | Propertient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or itema 23a or 28a-f show Examiner must be notified at

natural', or

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *na any Injury or other traumatic event, fre Medis DRCs.

72 hours after

Baitimore, Maryland 21215-0020

Box 68760,

Records, P.O.

Division of Vitai

Director

Funeral

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Completed

Be

Examiner 980

this deeth. > 24 hours after the Funeral Direction of Funeral Direction of the Funeral Direction of the Funeral Property (Filled in British Filled in

The Attending or Attendation after deeth Director:

State Registrar

edical To the Hosp within 24 ho To the Fune completely fi

Physician/Medical þ Completed Be To Certification:

27. Menner of Death

1 Netural 2 Accident

3 Suicide

29e. Certifier

4 Homicide

(Check only one)

PETER W. Fin MD 2 1999

29b. Signeture and title of certifier

5 Pending investigation

6 Could not be determined

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

. 7900 old Brand

28a. Dete of Injury (Month, Dev Year)

DUR 32. Registrar's Signeture

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

D12884 101 stinz

28c. Injury at Work?

(Secrifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29c. License number

1 TYes 2 TNo

anton

28d. Describe how injury occurred

Jan. 7

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

maryland 20735

JAN 1 2 1995

em # 31. PGC	ie (First, Middle, Las			Cer	tificati	e or i	Jealii		2. Date of Dec	Reg. No.	10.	Time of Death
an	cyl G. Mi								Month Januar	Day	Year	7:03AM
cai =	If not institution, give					4	b. City, To		ation of Death			7:03AH
51	gton Adver						Takor	na Pa	rk	Mo	ontgome	су
5. Social Security N			Age (In yrs.	last birthdey)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Der July 1		9. Birthplace (Stete or Foreign
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Usual Residenca o	10b. County		10c. Cit	y, Town or Lo	cation			-			10d. In	side City Limits
Maryland 10e. Street and Nu	Prince (Genrae's			Hva	tter	ille				1,1	Yes 2□No
10e. Street and Nu	-	000160 8			10f. Zip		1110		- 1	10g. Citizen of V	What Country?	
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3 - Widowed	15. Decedent's Ed	Year or Date	95 .	16a, Deced	lent's Usue	el Occup	ation			16b. Kind of Bu	Americ	
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	oseph Mil			1					aine F			
	eme/Relationship (_					or, City or Town,	State, Zip Code 20783)
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23a. Perri Enter	the disease, or compart failure. List only	plications that cau	sed the deet	h. Do not ente						Wash., I	Appr	oximate
snock or nea	in failure. List only	one cause on eac	n line.									val Between et end Death
Immediate Cause diseese or condition	(Final	. Cardi	er F	Free!	1							
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		b. Hyp	erter	sion							11	2411
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resulting in deeth)	Last		Due 19/0	as a conseq	uerica or):							2110
		d									i	
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Huno	chordo	ne s es							10	Yes 2□ No	3 Probably	4 Unknown
174/16	rlipide	N/OL							04- 14/-		24h Wasa s	stopsy findings
										an autopsy med?	evailable	prior to
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05 11/2	and to the state of								10'		1 Yes	2 No
25. Was case reference examiner?		Hospitel:	entiont of	EB/O.45-11	• • • • • • • • • • • • • • • • • • •	Oth	ar:		(Check only o	<i>ne)</i> dence 6 □Oth	or (Consider	
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3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	286. Placa of	Injury - At h	ome, larm, str	eet, factory	, office		2	8f. Location (S City or To		ber or Rural Rou	te Number,
		Conding	, s.c. topocii	,,								
29a. Certifier (Check only	1 ☐ Certifying Ph	iner: On the basi	s of exemine									cause(s)
one) 29b. Signature and		and manner					e number				nd (Month, Day,	1000
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1		ammala to disco	nd alone the day	0201 /7	D simt\							
1	ress of person who	0 1	of death (Item	n 23a) (Type,	Print)	- AL	1410	bol.	c PA	#3 K	lalmi	1 20710

from I would

988131 MAN.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath Day Month Yaer SAMUEL LEE MASON, SR. 13 99 1 10:54 PM 4a. Facility Name (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth 4475 Eastwicke, Drive Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 6. Sex 7. Aga (In yrs. last birthdey) 8. Deta of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) M 2DF Yrs. 218-12-1467 74 Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Wicomico Salisbury 1 Yes 2 No 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4475 Eastwicke Drive 21804 U.S.A. 12. Was Dacedent Evar in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puerto Ricen, atc.) 11. Marital Status 14. Race - Amarican Indien, Black, Whita, etc. 1 Naver Married 2 Married 1 GY as 2 □ No W.W.II If Yes, Giva Yeer or Dates: 1940 'S white 3 Widowad 4 Divorced Specify: 1940's 15. Dacedant's Educetion (Specify only highast grada complated) 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Poultry vaccinating 11 Eastern Shore e Laboratory company

18. Mother's Nama (First, Middla, Maidan Surnama) 17. Fathar's Nama (First, Middle, Last) Vernon Lee Mason Florence Lambertson(Byrd 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Julie Johnson, daughter 4475 Eastwicke Dr., Salisbury, Md. 21804 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Bates Cemetery 1/15/99 Snow Hill, Md. 21. Signature of Funaral Service Licensaa 22. Nama end Address of Fecility P.O. Box 87 Dennis Funeral Home, Snow Hill, Md. 21863 nnus 23a. Part1. Entar the disaasa, or complications that causad the death. Do not antar the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate interval Between Onsat and Death PNEUMONIA Immedieta Causa (Finel diseesa or condition rasulting in daath) Saquantially list conditions, if eny, leeding to immediata ceuse. Entar Undarlying Causa (Disaasa or injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Due to (or as e consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Dtd tobacco use contributs to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of ceuse of deeth? 24e. Wes an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 28. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 XResidence 6 ☐ Othar (Specify) 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred

/Medical **Examiner** The law requires that the death certificete be axecuted and Records, P.O. Box 68760 ettending physician for use as the buria signed by certificata has b lirector, paga 2 s Division of Vital Hospital or Attanding Physician: 24 hours after death.
Funeral Director: After this certifica tath filled in by the funeral director; p.

Examiner burial-tran Physician/Medical 98 þ Completed 8 70 Certification: To the Hospital o within 24 hours aff To the Funeral Di complataly filled in

Physician

/Medical

Examiner

Md.

Director

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or itams 23s or 28s-f show traumatic event, the Maxical Examinar name be notified at

the Maryland

filed within 72 hours eftar death

permit. Peges 1 and 2 should be filed within Department of Heelth and Mental Hygiene Important: If flam 27 is marked other than any injury or other traumatic avant

Physician

Baltimore, Maryland 21215-0020

25. Wes cesa referred to medicei 1 Yes 2 No 27. Manner of Death Natural 2 Accidant 5 Panding investigation 1 ☐ Yas 2 ☐ No 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 4 D Homicida 29a. Certifiar Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) and mennar as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated.

29b Signatura and title of continue

29c. Licansa number 29d. Date signed (Month, Day, Year)

002556

30. Name and eddress of person who cold inplated cause of deeth (Itam 23e) (Type, Print) 00

J. G. Santiano 21851

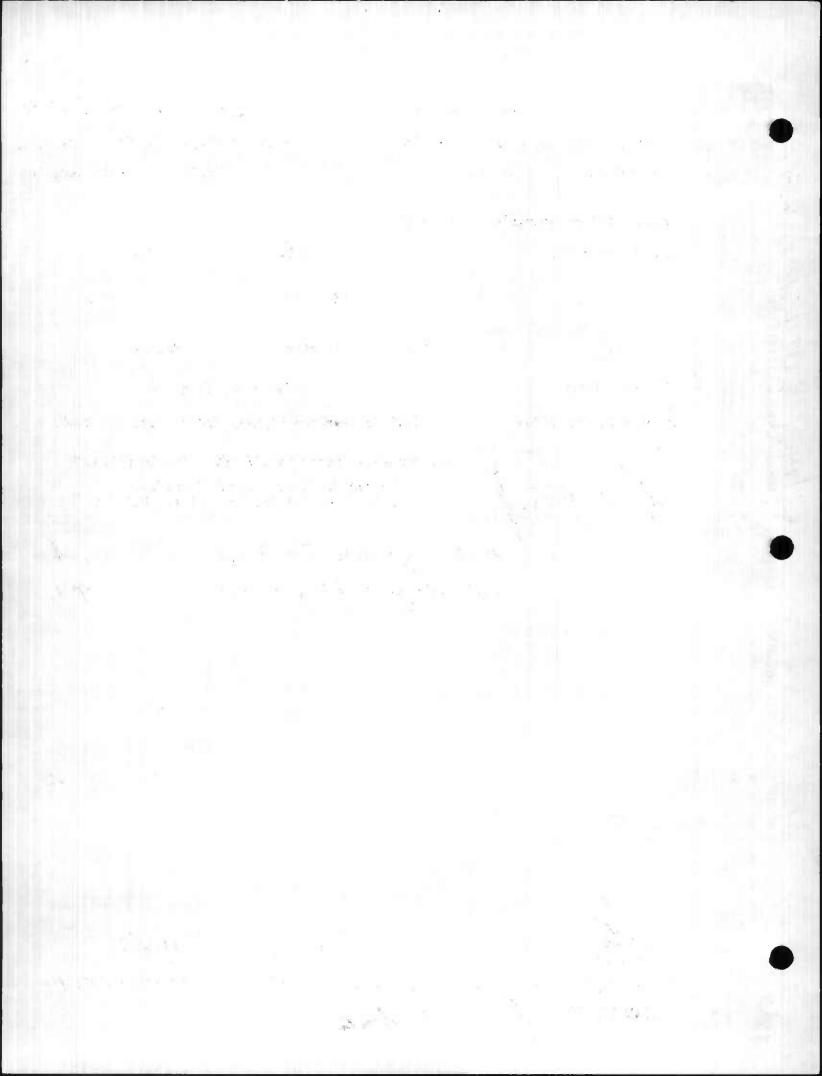
31. Data filed (Month State Registrar

Pocomoke 32. Registrar's Signatura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Maryland Prince Ge	orge's 0x	on Hill	f. Zip Coda				10g. Citizan of	What Coun	1 Yes 2 No		
1707 Iverson St.				20745			USA				
11. Marital Status 1 ☐ Nevar Married 2 ☐ Married 3 ☐ Widowad 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes XXNo If Yes, Give Yaar or Dates:		Decedent of long specify Cut	Hispanic Origi pan, Mexican, Specify:	n? (Spec Puerto R	ify Yas or No ican, etc.)	Bia	ca - Americ ck, Whita, y: Whit	atc.		
15. Decedent's Edi (Specify only highest grad Elemantary/Secondary (0-12) 11th	ucation fe complated) College (1-4or 5+)	16a. Decedant's (Give kind o life. DO No Personne	of work done OT use retire	during most o	of working	g	16b. Kind of B		dustry		
17. Fathar's Nama (First, Middle, Last) Luther Owen				Sal	.1y M	lay Tha	99				
19a. Informant's Name/Relationship (7) Stephen R. Sandy/	,, ,,	19b. Mailing Add					er, City or Town ian Head				
20a. Method of Disposition	20b.	Place of Disposition cematery, crematory				Date	20c. Location				
1) Durial 2 Cremation 3 4 Donation 5 Other (Specify	nemoval from Stata	. Barnaba			1.1/1	6/99	Temple	Hills	s,MD.		
21. Signature of Funeral Service Licens	100	Geor 22. Nan	ne and Addr	ass of Facility	Fune	ral Ho	ome.P.A.				
22. Name and Addrass of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, MD.20745											
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1420 JANUARY **Physician** CHARLES ANDREW PALMER /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner CHEVERLY PRINCE GLORGES PRINCE GEORGES HOSP (TAL CENTER If Undar 24 Hrs. 7. Aga (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax **Funeral** Months Days \$□ M 2□ F Hours 214-19-8169 January 10, 1981 California 18 Director Usual Rasidance of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits must be notified at 1 Yes No Maryland Charles Directo Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with 8533 Round Hill Road 20622 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Give Year or Dates: r than "natural", or items the Medical Examiner ma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race · Amarican Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Marriad 2 Married 1 ☐ Yes 2 No Specify: Maryland 21215-0020 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry al Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Student School traumatic event. 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) 12 should be fill ond Mental H William Johnson Palmer, Jr. Catherine N. Wengerd 19e. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 s nant of Heelth en ant: If item 27 is William J. Palmer, Jr.-Father 8533 Round Hill Rd., Charlotte Hall, MD 20622 other Baltimore, 20b. Plece of Disposition (Neme of cametery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State Injury or Department of important: If any injury or once. Charles Memorial Gds. 1-16-99 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of European Sproop Licensee 22. Name and Address of Facility Home, Inc. Dus John P. Krisley M01164 P. O. Box 156, Waldorf, MD 20604-0156 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heef failure. List only one cause on each line. Approximate interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final MULTIPLE INJURIES disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner certificate be executed physicien end the buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of) usa as 1 for signed by the a Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Records, g 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peen completion of cause of deeth? 99 paga 2 1 Yas 2 No 1 ☐ Yes 2 ☐ No cartificete Division of Vital director, 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2□ No After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred ALLEGED PASSENGER OF A Certification: 2051 M Hospital or Attending 1 Natural 5 Pending after daath. 1 ☐ Yes 2 No 01-10-99 VAN VS AUTO COLLISION 2 Accident 6 Could not be 28f. Location (Street and Number of Rural Route Number MD City or Town, State) MECHANICS VILLE, MD 28e. Place of Injury - At hon building, etc. (Specify) At home, farm, street, factory, office in by 4 I Homicide THREE NOTCH ROAD & GOLDEN BEACH AG STREET 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifian (Check only one) minetion and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) To the I 29d. Date signed (Month, Day, Year) PRIVE CHEVERLY, MARYLAND 2078S

State Registrar

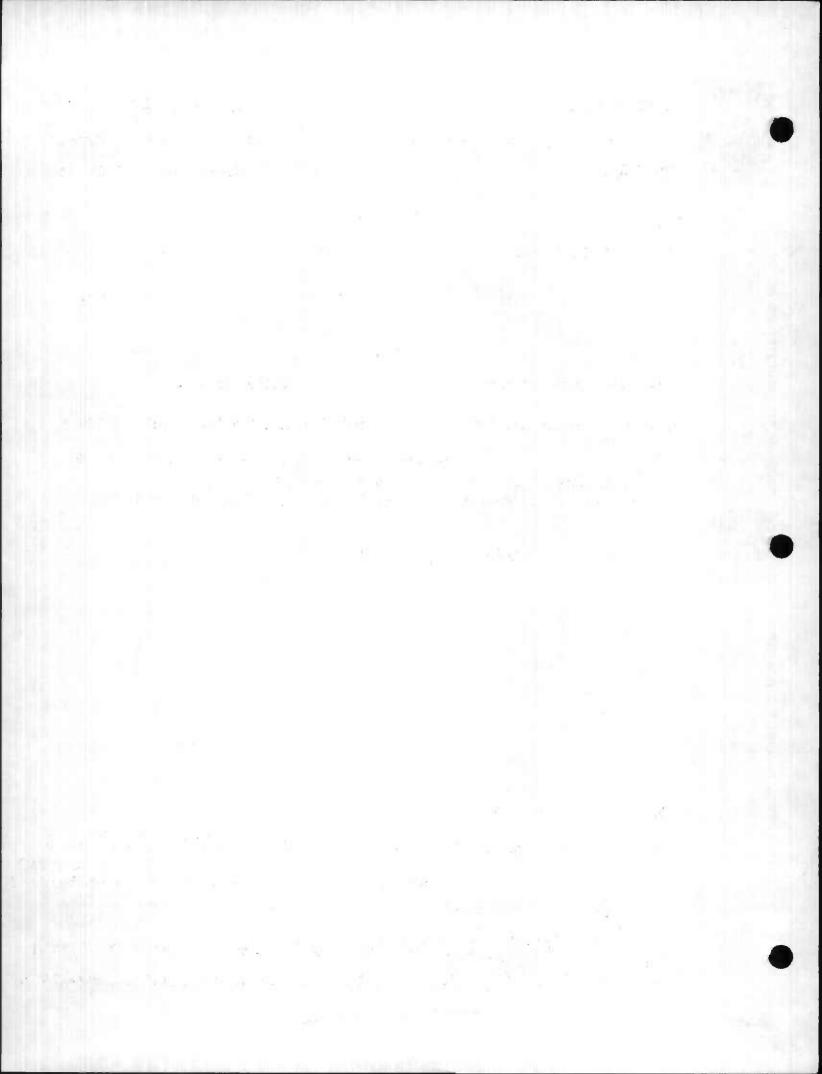
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32. Registrar's Signature

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				State of W	laryiari		tificate of	Death		Reg. No.		
	Physician	1. Decedent's Neme							2. Dete of Dea Month	nth Day	Year 1999	3. Time of Death
	/Medical Examiner	4a Facility Name (If r			gers			4b. City, Town, or I	ocation of Death	4c. County	-	x. 2 1011
	Funeral Director	5. Social Security Nur 579-26-53	6. So 309A	Adventis	ge (In yrs. I	spita (ast birthday) 4 Yrs.		If Under 24 Hrs.	8. Dete of Birth (Month, Det 10/23/	h (, Year)		nery ace (State or Foreign try) SBURY, NC
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Ball Permit.	Department Important: eny Injury price.	21. Signature of Fund	ral Service Ligan	mille	a)	S	Name and Addr	ess of Facility John St., N.	hn T. E. Was		Com 200	
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** January 13,1999° 6:50A LEO FRANCIS SMITH SR /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Civista Medical Center La Plata Charles If Undar 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Birthplaca (Stata or Foreign Country) Days 1**⋈** M 2□ F Hours Yrs. Director 579-07-3980 SEPT. 5 1918 Washington, DC 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits traumatic event, the Medical Examiner must be nothing at Director 1 TYas 2 No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2009 St Thomas Drive 20602 Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 M Yas 2 No If Yes, Giva Year or Datas: WW 11 1 Nevar Married 2 Married Specify: White by 3 Widowed 4 Divorcad Completed 15. Dacedant's Education (Specify only highast greda complated) Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. ant: If item 27 is marked other than "rury or other traumatic event, IIIe Med Elamantary/Secondary (0-12) Collega (1-4or 5+) Administrator US Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama) Be William Smith Sr Teresa Gardner Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3609 Glenbrook Rd Fairfax, VA 22031
Data 20c. Location - City or Town, State Mary C. Angelo (daughter) 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other pleca) Burial 2 Cramation 3 Ramoval from Stata permit. Page Department of Important: If any Injury or once. ition 5 Othar (Specify) Maryland Veterans Cem. 1-21-99 Cheltenham, MD 21. Signature of Fat 22. Nama and Addrass of Facility M00173 J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695 ter the disaase, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, haart failure. List only one cause on each lina. Approximeta Intarval Batween Onsat and Deeth **Physiclan** /Medical Immadiata Causa (Final disaasa or condition resulting in death) Examiner Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avents rasulting in daeth) Last Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No Be 25. Was case ratarred to medical axeminar? 26. Place of Deeth (Check only ona) 2 1□ Yas 2□ No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 1 Impatiant 2 ER/Outpatient 3 DOA Certification: 27. Menngrot Death 28a. Deta of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury et Work? 1 Natural 5 Panding 1 Yas 2 No invastigation 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, straat, factory, office bullding, atc. (Spacify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) 29a, Cartifian Medical (Check only one) 29b. Signatura and titla of codific 29c. Licensa number 29d. Date signed (Month, Day, Year) D-22574 pleted cause of daath (Itam 23a) (Type, Print) Robert T. Pace, MD. 12070 Old Line Center, Suite 202, Waldorf, Maryland 20601 32. Registrer's Signatura State

DHMH 16 Rev 6/95

Registrar

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Division Attending

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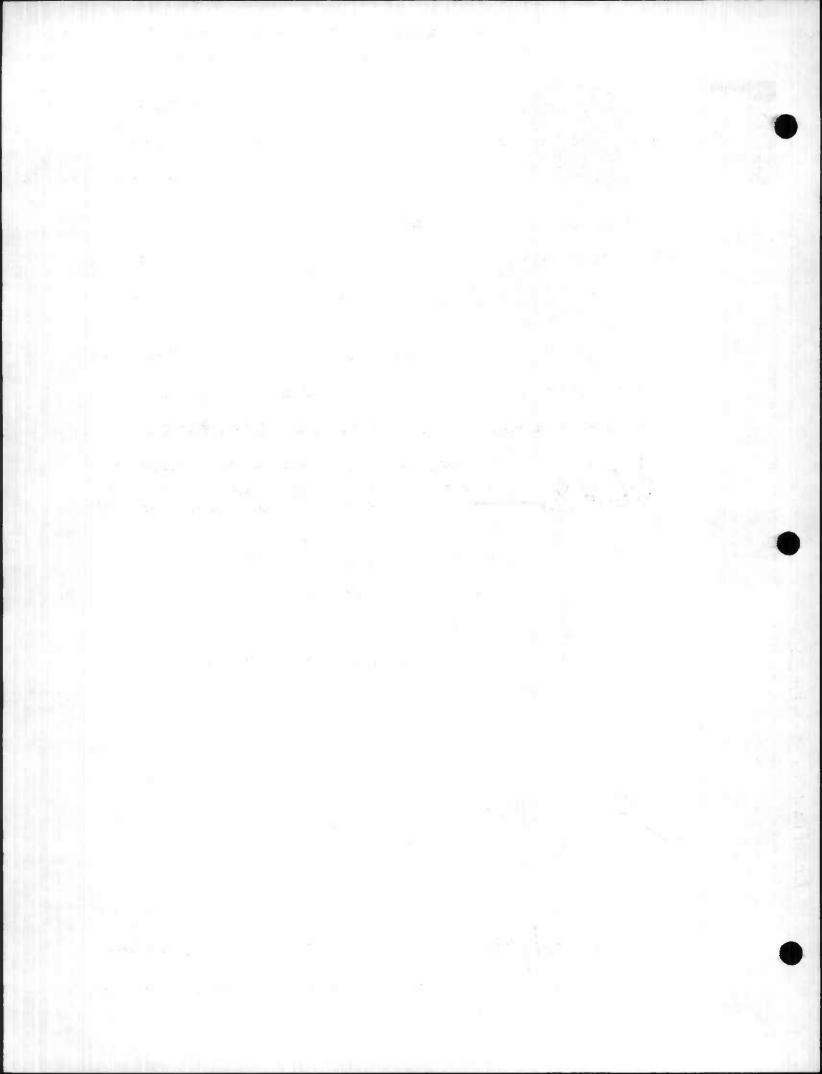
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Baltimore, Maryland 21215-0020



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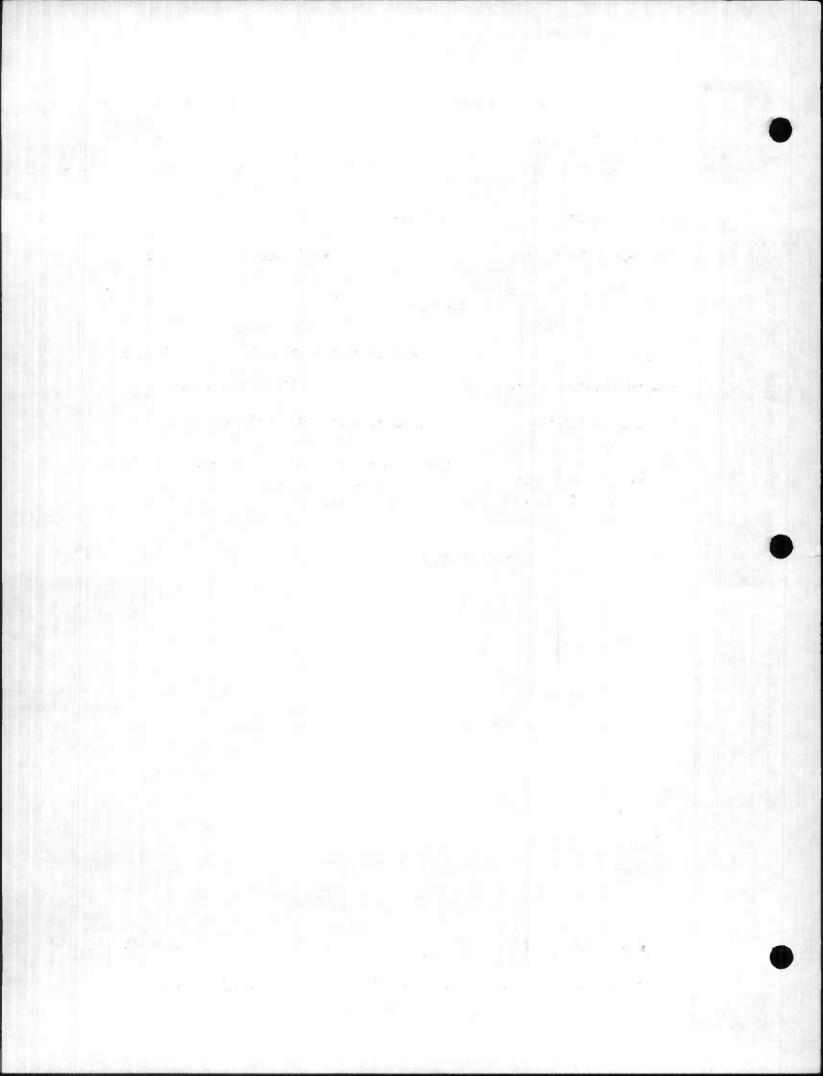
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Physicia /Medic		1. Decedent's Nama (First, Middle, Last) BENJAMINE FRANCES STONE 4a Facility Nama (If not institution, give street and number) 3149 APPLE CREEK LANE				WALDOR				JANUARY 11,199		3. Time of Death 5:55AM	
Examin									wn, or Location of Do	CHA	CHARLES		
Funeral Director		5. Social Security Number 6. Sec. 579-24-3939 Usual Rasidance of Decedent	79-24-3939 ^{₹⊡м 2□F} 72						If Under 24 Hrs. Hours Min. June 1, Month, Pay,		9. Birthplace (State or For Country) Washington D(
within 72 hours after death with the Manyland with a "natural", or items 23e or 28e-f show it an "natural", or items and be northed at the Madical Examiner must be northed at	ctor	Maryland Charles Wa				r, Town or Location Idorf				10d. Inside City Limi 1 □ Yes 🌂 📉			
	ral Directo	10e. Street and Number 3149 Apple Creek Lane				10f. Zip Coda 2060				10g. Citizan of What Country? USA			
	by Funeral	11. Maritel Stetus 1 □ Navar Married 2 ☑ Married 3 □ Widowad 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☑ Yas 2 □ No If Yas, Giva Year or Datas: 194			If Yas, specify Cuban, Maxican, Pua				gin? (Specify Yas or , Puarto Rican, atc.)	ify Yas or No- can, atc.) 14. Race - Amarican Indian, Black, White, etc. Specify: White			
	Completed	15. Decedent's Education (Spacify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+)				Decedant's Usual Occupation (Giva kind of work dona during most of work Iffa. DO NOT usa ratired) Visual Display Manage				16b. Kind of Business/Industry Retail			
2 should be filed and Mental Hygis Is marked other aumetic event, it	To Be Co	17. Father's Nama (First, Middla, Last) Edward Theodore Stone				18. Mothar's Nar			r's Nama (First, Mio	gnes Russell			
D564		19a. Informant's Name/Ralationship (Type, Print) Debra L. Grigsby				19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 2900 Hunt Ct., Waldorf, MD 20603							
permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		1 ☐ Burlal 2 ☐XCramation 3 ☐ Ramoval from Stata				laca of Disposition (Nama of amatary, cramatory or other pleca)			1-14-9	Data 20c. Location - City or Town, Stata 14-99 Waldorf, MD			
permit. Departimporta		21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604											
Physician /Medical Examiner		23a. Part1. Entar tha disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ceuse (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence of):										Approximata Interval Between Onset and Daath	
leath certificate be axecuted attending physicien and for use as the burial-transit	y Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Undarying Causa (Diseasa or Injury											
		thet initieted events rasulting in death) Last Dua to (or as a consequanca of): d											
0 0 %		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give						an in Part I.	In Part I. 23b. Did tobacco use contribute to the cause of dea				
aw requi	Completed by									Was en eutopsy performad? 24b. Wera autopsy finding available prior to complation of cause of death?			
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Physician: The this certificate ral director, pag	o Be	25. Was casa referred to medical examinar? 1 ☐ Yes 2 ☒ No	26. Placa of Death (Check only ona) dospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify)										
는 문들	ation: T	27. Mannar of Death 1 XNatural 5 Pending 2 Accidant Investigation	28e. Data of Inj (Month, Da									,,	
To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: Aftar thi completaly filled in by the funeral	Certification:	3 Suicida 6 Could not be determined	28e. Place of Injury - At home, ferm, straat, factory, offica building, atc. (Specify)						City or	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)			
	edical	29e. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.											
To th within To th	M	29b. Signatura and titla of cartifier 29c. License number D28352 DANUARY 1.											

State Registrar 31. Data filad (Month, Day, Year) JAN 15 1999 32. Registrar's Signatura

30. Name and eddrass of person who complated cause of death (Item 23a) (Type, Print)

KRISHAN MATHUR, M.D P.O. BOX 2729, LA PLATA, MD

20646



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) Month 8 **Physician** LINE Jan The era /Medical 4b. City, Town, or Location of Deeth 4a Fecility Nema (If not institution, give street end number) 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery 7. Aga (In yrs. lest birthday) If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sax 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□M 2X F Months Deys Hours Yrs. 74 577-24-2684 April 8, 1924 Maryland Usual Residence of Decedent 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Directo Maryland | Prince George's Bowie 10e Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 13215 Overbrook Lane 20715 U.S.A. Funeral 12. Was Decadent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Montgomery County Elementery/Secondery (0-12) College (1-4or 5+) Budget Analyst Board Of Education 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middla, Last) Be Charles Reed Ada Kaiser 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 12006 Rockledge Drive, Bowie, Maryland 20715 Evelyn S. Vartabedian - Daughter 20b. Piece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 01/20/99 4 ☐ Donetion 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility
Gasch's Funeral Home, P.A. ean 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part : Enter the disease shock, or heart feilure e complications that caused the delimited only one cause on each line. Approximete Intervel Between Onset end Deeth Do not enter the mode of dying, such as cerdiec or respiratory errast, Immediate Cause (Final disease or condition resulting in death) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Last Dua to (or es e consequence of): Physician/Medical Dua to (or as e consequance of): 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4∑ Unknown NRN à 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No 25. Wes cese referred to medicel exeminer? 26. Plece of Deeth (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2X No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1X Neturei 5 Pending 1 Yes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Phyelclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one)

DHMH 16 Rev 6/95

Funeral

Director

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nd 2 should be filed within 72 lth and Mentel Hygiane. 27 Is marked other than "na r treumatic event, I'm Medil

Pages 1 end 2 siment of Health an ant: If Item 27 is rury or other treus

permit. Page Department of Important: If eny injury or once.

Physician /Medical

Examiner

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death certificate be executed

Box 68760.

Division of Vital Records,

Attending

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• Funeral Dire lately filled in b ŏ

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death

72 hours after

Baltimore, Maryland 21215-0020

State Registrar

31. Date filed (Month, Dey, Year)

29b. Signature and tale of certifiar

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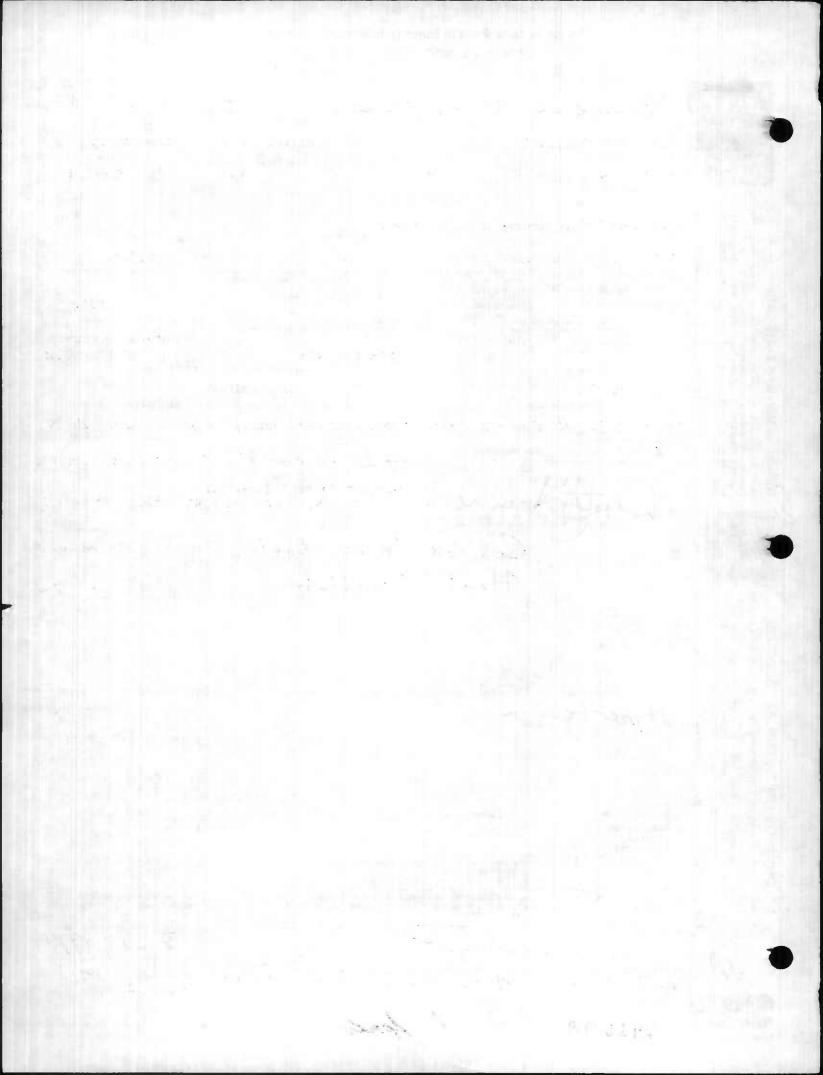
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

29c. License number

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29d. Dete signed (Month, Dey, Year)

The Some



			Certificate of	f Death	Re	eg. No,		
Physician	Decedent's Nema (First, Middle, La.		G 354 H		2. Dete of Deat Month	Dev Y	3. Tima of	
/Medical	MARY ELIZABETH S 4e. Fecility Neme (If not institution, give			4h City Tourn or I	January			AM
Examiner		in a second seco		4b. City, Town, or L	ocation of Deeth	4c. County of		
Funeral	DOCTOR'S COMMUNIT 5. Social Security Number 6. S		t birthday) If Under 1 Yea	LANHAM ir If Under 24 Hrs.	8. Dete of Birth		GEORGE S	r Forein
Director -	578-30-3511 Usuel Residence of Decedent	□M 2XIF 83	Yrs. Months Days	s Hours Min.	8. Dete of Birth (Month, Dey, August 7,	1915 W	Birthplece (Stele of Country) Shington, L).C.
show show	10a. Stete 10b. County	10c. City, 7	Town or Location				10d. Inside Clt	y Limits
or 28a-4s be notified	Maryland Prince (George's 1	New Carrollto	on			12 Yas	2 🗆 No
or 22	10e. Street and Number		10f. Zip Code		10	0g. Citizan of Who	et Country?	
an le	7867 Riverdale Ro	ad	20	784		U.S.A		
use after death with the Maryle alt, or frem 23e or 28e-f sho Exerning must be notified at by Funeral Director	11. Meritel Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2∑ No If Yes, Giva Yaar or Detes: 	13. Was Decedent of If Yes, specify Cul		pecify Yas or No- Rican, etc.)		American Indian, White, etc.	
"natural" edical Ex	15. Decedent's Ed	ucation	16e. Decedent's Usuel Occu	upation		16b. Kind of Busir	Black ness/Industry	
	(Specify only highast gre	de completed) College (1-4or 5+)	(Give kind of work done life. DO NOT use retin	e during most of work ed)	ring	D		
Somp	9th	Collogo (1 401 51)	Housewi	fe		Private		
e se	17. Fether's Neme (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N	feidan Sumeme)		
	Thomas Fletcher			Mary Be	1t			
4.2.5	19e. Informent's Neme/Reletionship (7	Type, Print)	19b. Meiling Address (Stree	et and Number or Ru	ral Route Number,	City or Town, St	ete, Zip Code)	
= N +	Antionette Gray/D		025 Billsing	ley Road,	Bryan R	oad, Mar	yland 206	16
if item or othe	20e. Method of Disposition 1 Buriel 2 □ Cremetlon 3 □	Removel from State	e of Disposition (Neme of etery, crametory or other plants	ece)	O1/14	20c. Location - Cit	y or Town, State	
4 4 4	4 □ Donetion 5 □ Other (Specify		ony Memorial	Park		Landover	, Marylan	G
Department Important: any Injury SDS:	21. Signature of Funaral Service Licen	saa	22. Nama and Addr					
6 2 2 0	Nanay A.	Percente	J.B. JENKI 7474 Lando			r Marul	and 20785	
nysiclan	23e. Pert1. Enter the dispese, or comp shock, or hear failtra. List only of	one ceuse on each line.	Do not enter the mode of dy	ring, such es cardiec	or respiratory erra	est,	Approximate Interval Betw Onset and D	9
Medical	Immediate Cause (Final disease or condition	CONGE	STIVE	HEART	FA	LIURF	IOYE	AR
kaminer	resulting In deeth)	Due to (or ea	s e consequence of):					
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bunal-transit	Sequentially list conditions,		e consequence of):				1110	10
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page 2 should					24e. Wes er perform	ned?	aveileble prior to completion of ca)
has ge 2 mp							of death?	
certificata harector, page					1 □ Ye	s 2 No	1 □ Yes 2 □ I	No
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this cral directal directal	1 ☐ Yas 2 ☐ No 27. Menner of Deeth	1 Inpatient 2 LER	Outpetient 3LI DOA	4 LI Nursing Ho	me 5 Reside		(Specify)	
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within 24 hours after death. To the Funeral Director: After t completely filled in by the funer Medical Certification:	4 ☐ HomicIde detarminad	28a. Place of Injury - At home building, etc. (Specify)	, ानामा, आ <i>वन</i> ा, ग्रहारा ग्य, ०गी००	,	City or Town	, State)	or Rural Route Numb) 0 1,
within 24 hours are To the Funeral I completaly filled	29a. Certifler 1 Certifying Phy	aician: To the best of my knowle	doe death occurred at the ti-	ime date and place	and due to the	uea/e) and	or an atriad	
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Me Me	29b. Signeture end title of certifier	1 11	∕n 29c. Llcan	ise number	29	d. Data signed (#	fonth, Dev. Year)	
7	VP ST	L HTTand.	Phys D	19597		1. 110	79	
4)	30 Name and address of parent ut	ompleted cause of death (the case	let (Turno Print)	1101)			1	
1	30. Neme and eddress of person who c	on A HA COVE	PARKUA	Y GREE	N 55 LT	mo	2077	0

State Registrar

JAN 1 4 1999

31. Dete filed (Month, Day, Yeer)



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	State of Maryland / Department of Health and M	flental Hygiene 9 9 0 9	18
	Certificate of Death	Beg No.	

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	Physician
	/Medical
	Examiner

3. Time of Death 9:50 A

1 Yes 2 □ No

GEORGES

Funeral Director

28a-f show 8 or herns 23a 72 hours after

Director

Funeral

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Completed

Be

ified within 72 hours i l'hygiene. other than "natural", c

Pages 1 and 2 should be filed view of Heelth end Mental Hygient: If item 27 la marked other t permit. Page Department of Important: If any Injury or once.

Baltimore, Maryland 21215-0020

Box 68760

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Records,

Division of Vital

Physician /Medical Examiner

Examiner physicien and s the bunal-transit Physician/Medical 3 bengis be ad p P Completed certificate Be 2 To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera edical Certification:

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ferrell Stewart Gibson JANUARY 06 1999 4a Facility Name (If not Institution, give street and number)
PRINCE GEORGES HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death CHEVERLY PRINCE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 MM 2□ F 226-42-3720 61 Yrs Oct. 25, 1937 VIRGINIA Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Alexandria VA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Kennedy Strect U.S.A. 22305 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 D(Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 Ø Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Delivery Svc. Truck DRIVER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Lara Stewart moxley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandria, Va. 22305 22 Kennedy St., Phyzell Gordon / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Stewart Family Cometery 1-14-99 Rectortown, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licer Joynes Funeral Home Warrenton, Va. P.O. BOX 3633 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiovascular Immediate Cause (Final disease or condition resulting in death) sease Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 24a. Was an autopsy

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of gleath? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 MYes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 30XDOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

920

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) JANUARY 07, 1999

and obditions of person who completed cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar

32 Registrar's Signature

Sec. 2 Mal

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physiciar /Medica Examine	i
ر Funerai	

the Maryland 7 is marked other than "natural", or flems 23s or 28a-f show traumatic event, the Medical Examinar must be notified all with death 72 hours after permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, the Media once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

The law requires that the death certificate be executed physician and as the burial-trans Box 68760. attending p P.O. signed by the Records, page 2 should certificate has Division of Vital Attending Physician: this After t

Hospital or To the Hospital of within 24 hours a To the Funeral Completely filled Registrar

1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day VASSILIKE STAVROPOULOS JANUARY 6, 1999 4:00 P.M. 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death MANOR CARE NURSING HOME MONTGOMERY POTOMAC | Months | Days | Hours | Min. | B. Data of Birth | 9. Birthplaca | Months | Days | Hours | Min. | MARCH 15, 1903 | GREECE 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1□M 2XF 95 Yrs. 578-24-7559 Usual Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD MONTGOMERY POTOMAC 1 Yas 2□No Director 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 11112 SMOKEY QUARTZ LANE 20854 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ፫ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, White, atc. 1 ☐ Naver Marriad 2 ☐ Marriad 1 ☐ Yas 2 No Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) 8 HOMEMAKER OWN HOME 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be EDWARD ARGERAKE CHRISTINA KOUTSIKOS 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) CHRISTINA KOUSIS 11112 SMOKEY QUARTZ LANE, POTOMAC MD 20854 DAUGHTER 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Ramoval from Stata PARKLAWN MEMORIAL PARK 1/11/99 ROCKVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Spacify) 22. Nama and Addrass of Facility
JOSEPH GAWLER 'S SONS, INC. 5130 WISCONSIN AVENUE NW, WASHINGTON, DC 20016 or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Intarval Batwaan Onset and Death tmmediata Causa (Final disaasa or condition rasulting in death) Examiner Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury that Initiatad avants rasulting in daath) Last Due to fatiles a consequence of Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Pending invastigation Natural 1 Yas 2 No 2 Accidant 3 Sulcida 6 ☐ Could not be datarminad 28a. Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida edical 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinar: On the basis of examination and/or Invastigation, In my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29b. Signature and late of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed causa of death (item 23a) (Type, Print) 9410 OLD GEORGETOWN ROAD, BETHESDA, MD 20814 DAVID A. BLASS, M.D., 32 Registrar's Signatura 31. Data filed (Month, Day, Year) State

JAN 1 3 1999

SAN THE STATE OF T

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				100		Ce	rtificate of	Death			eg. No.		
oioion	1. Deced	ent's Name (First, Mic	ddle, Last)	1,300		2117			2	2. Date of Dear Month	th Day	Year	3. Time of Death
sician ledical		Russell Ja	ames Sn	nith,	Sr.					Januar		1999	4:52PM
aminer	4a Facilit	y Name (If not institu						4b. City, Tow	vn, or Loca	ation of Death	4c. County		
_	r. 0i-1	Prince Ge	-			form a for finally referred	If Under 1 Year		ever1				orge's
ral or		Security Number 28–2046	6. Sex	2□ F /.	66	last birthday) Yrs.	Months Days			B. Date of Birth (Month, Dey			lace (State or Forei
		sidence of Decedent			00					June 1	/ 1932	Ma	ryland
	10a. State 10b. County 10c. City, Town or Location										1	Od. inside City Limit	
ctor	Mary	land Princ	ce Geor	rge's		(Capitol I	Heights	5				1 X Yes 2 □ N
Sire	10e. Stre	et and Number	-	12-17-1			10f. Zip Code			1	0g. Citizen of V	Whet Coun	try?
rail	4	315 R Stre	eet					20743				ed St	
une	11. Marita			Armed Force		,S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Orlg ban, Mexican,	in? (Spec Puerto R	ify Yes or No- ican, etc.)		ce - Americ ck, White,	
by Funeral Director		ever Married 2 XM		1 ☐ Yes 2 If Yes, Give			1□ Yes 2♥ No				Specify	y: R1	ack
D D	3 🗆 🗸	Vidowed 4 Divord		Year or Date	os:	100 D-00	death Henri Ose	.mation			16b, Kind of B		
ete		(Specify only high		m <i>pleted)</i>		(Give	dent's Usuai Occu kind of work done DO NOT use retir	apation a during most adi	of working	7	160. Kind of B	usiness/inc	lusity
Completed	Elemen	ntery/Secondary (0-12 9th	2)	College (1-4	or 5+)		cuck Driv				Pr	ivate	
	17. Fathe	r's Name (First, Midd	le, Last)					18. Mother	r's Name (First, Middle,	Maiden Suman	ne)	
To Be		Walter Mar	shall							Matilda	a Smith		
-	19a. Info	rmant's Name/Relation	onship (Type,	Print)	- 7	19b. Malli	ing Address (Stree	et end Numbe					Code)
	Ali	ce M. Smit	h - Wi	.fe		500) - 61st	Street	, N.	E. Wash	nington	, D.C	. 20019
		nod of Disposition				Place of Disponentery, cre	osition (Name of matory or other pl	ace) Park	- 1	Date	20c. Location -	- City or To	wn, State
		Burial 2 ☐ Crematio Donation 5 ☐ Other		oval from Sta	416		Nationa		- 1	15/99	Laur	el, M	D
	21. Signa	ature of Funeral Servi	ce Licensee		^		2. Name and Add	-		-	Funera		
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er	resulting	in death)	a			or as a conse	al Fibri	110110	111			1	
cai Examiner	that initia	ally list conditions, ading to immediate inter Underlying Disease or Injury ted events	c	Ca	Due to (d	or es a conse	y Arrest quenca of):						
	that initia	ally list conditions, ading to immediate inter Underlying Disease or Injury ted events in death) Last	c	Са	Due to (d		y Arrest quenca of):						
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	resulting	in death) Last	c		Due to (d	or es a conse	y Arrest quenca of): quence of):						o the cause of deat bebly 4 ⊠Unkno
by Physician/Medicai	resulting	in death) Last	c		Due to (d	or es a conse	y Arrest quenca of): quence of):				res 2□ No	3 Prol	The second states
by Physician/Medical	resulting	in death) Last	c		Due to (d	or es a conse	y Arrest quenca of): quence of):			1 □ 1 24a. Was a	res 2□ No an autopsy med?	3 Prol	bably 4 XIInkno are autopsy finding- allable prior to mpletion of cause
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DHMH 16 Rev 6/95

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		The Mark			Cei	rtificate	e of	Death		1	Reg. No.		
Physic		Decedent's Name (First, Middle, Las DOR	OIS L. S	SEGELH	IORSI	,				2. Dete of Dee	9, 199	Yeer 9	3. Time of Deeth 2:25 AM
/Medi Exami		4e. Fecility Neme (If not institution, give						4b. City, Too		ocation of Deeth	4c. County	of Death	MERY CO.
Funeral Director		5. Social Security Number 6. Se 168-09-1251	7. A	Age (In yrs. les	st birthday) Yrs.	If Under Months	1 Yeer Deys	If Under 2 Hours	24 Hrs. Min.	8. Dete of Birt (Month, De) JULY 14	r, Year)		plece (State or Foreign htry) GLAND
Maryland a-f show	tor	Usuel Residence of Decedent 10e. State 10b. County MD • MONTGOME	CRY	10c. City,	Town or Lo	cation	Æ						10d. Inside City Limits 1) Yes 2 □ No
h with the	ai Director	10e. Street end Number 9701- VEIRS	DRIVE			10f. Zip	Code 208	350			10g. Citizen of US A		ntry?
filed within 72 hours effer death with the Maryland Hygiene. ther then "netural", or terms 23a or 28a-f show ont, tre Medical Exertites must be notified at	by Funeral	11. Marital Stetus 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates	₹No	i	Wes Deced f Yes, spec	ify Cube	ispenic Orig en, Mexican Specify:	gin? (Sp , Puerto	pecify Yes or No- Ricen, etc.)		ck, White,	can Indien, etc. HITE
within 72 ho ane. then "netur	Completed	15. Decedent's Edu (Specify only highest gred Elementery/Secondery (0-12)			(Give life. I	dent's Usue kind of wor DO NOT us ECRET	k done d e retired	during most t)	of work	ring	16b. Kind of B		
should be filed within the Mental Hygiane. marked other then imatic event, the Mental Hygiane.	To Be Co	12 17. Father's Neme (First, Middle, Last) JAMES LEONAR	RD		- 01	CKDI				e (First, Middle,	Meiden Sumen	ne)	
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death certificeta be executed By Alexandre as the bunel-transit Control of the	In/Medical Examiner	Z3a. Part 1. Enter the disease, or bond shook, or heart fature. List only of immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	ications that cause on each a	Duano (or a Due to	s a consequence a consequence	we the mode	he of dying	g such as of	tie	wash or respiratory are	agus		Approximate interval Between Onset and Death 7 day 7 day Years Years
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s been s	Completed b									24e. Wes e perfor	med?	co	ere eutopsy findings ellable prior to mpletion of ceuse deeth?
certifica rector,	o Be C	25. Wes cese referred to medicel exeminer?	lospitel:	last 2DEC	2/Outpation	t 3□ DO	Othe	ar.		h (Check only or	ne)		
After fune	ation: T	27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Dete of Inj (Month, De	ury 28	Bb. Time of injury		Bc. Injury Work			28d. Describe h			<i>n</i>
X = = =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury - At home etc. (Specify)	e, farm, stre	eet, fectory,	, office			28f. Location (S City or Tow		er or Rura	al Route Number,
To the Hospital or within 24 hours effe To the Funeral Dir completaly filled in	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ner: On the best and menner s	of exeminetion	dge, deeth and/or inv	occurred e restigetion,	t the tim	ne, dete end pinlon, deetl	l plece, h occur	end due to the c red et tha time, c	ause(s) end me late end plece,	enner es si and due to	leted. the ceuse(s)
To t To t	2	29b. Signeture and title of certifier	W./6	west	~	290.	License)2/	number 726			lone Signe	d (Month,	Day, Year)
6		30. Name and address of person who co					RS I	DR.,	ROC	KVILLE	,MD.	1-11	1

DHMH 16 Rev 6/95

State Registrar 31. Dete filed Month, Bay 2 999

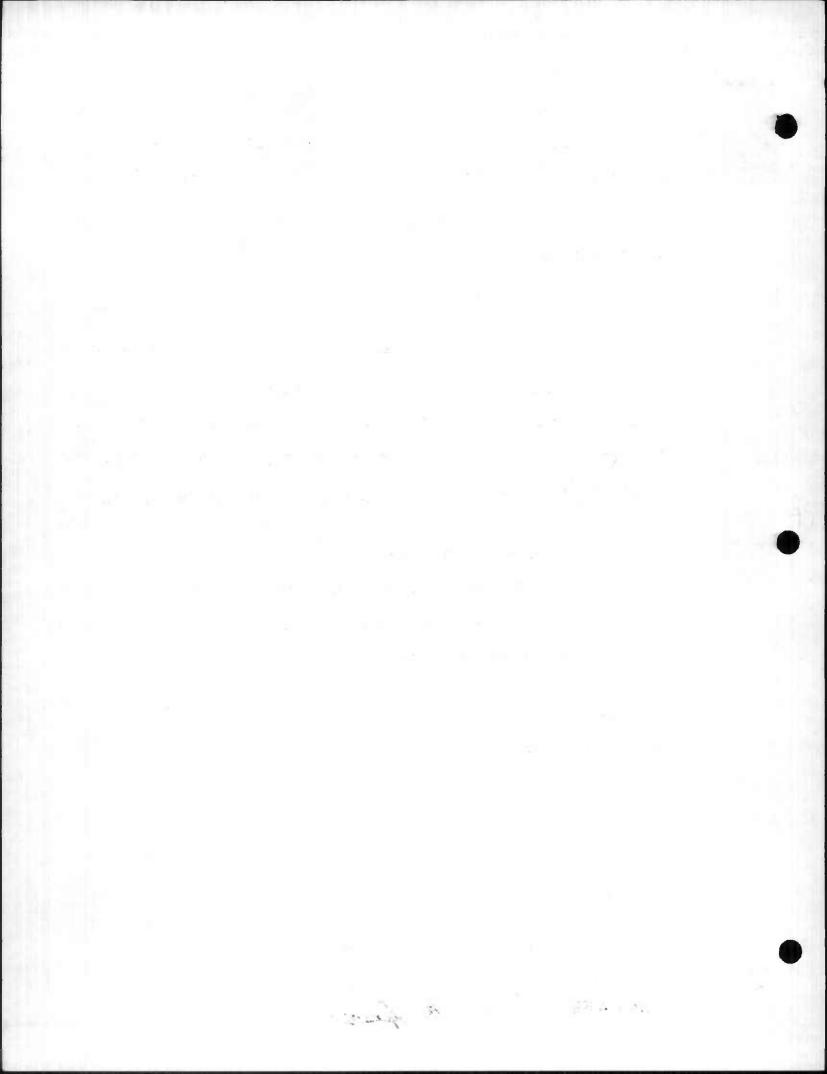
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State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death		Reg. No.		
			1. Decedent's Name (First, Middle, L.	ast)					2. Dete of De			3. Time of Deeth
	Physic		Annie Ste	wart					Month 1	Dey 7	Year 99	12:35am
	/Medi Examir		4e. Fecility Neme (If not institution, gr)			4b. City, Town, or L	ocation of Deel			12:33dill
	Exami	101	Mainer Health	s. Pehah	Con	tor		Rockvil	1.0			2011
Н	Funerai		5. Sociel Security Number 6.	Sex 7. A	ge (In yrs. las	t birthdey)	If Under 1 Yes	r If Under 24 Hrs.	8. Dete of Bi (Month, D	Mont	9. Birthol	L Y lece (Stete or Foreign try)
	Director		579-28-4005 Usual Residence of Decedent	1□ M 2□xF 8	6	Yrs.	Months Dey:	s Hours Min.		oy, Year) 0/12	Pa.	ry)
	work.		10a. Stete 10b. County 10c. City, Town or Location								10	Od. Inside City Limits
	Me I	ţō			Wash	inata	n, DC					1☐Yes 2☐No
	r 28a	5	10e. Street end Number				10f. Zip Code	îi		10g. Citizen of V	Whet Count	iry?
	3a o	0	30 P Street N	W			200	0.1		USA		
	death	Funeral Director	11. Marital Status	12. Was Decedent		13. W		Hispenic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No		a - America	an Indien,
Maryland 21215-0020	be filed within 72 hours after death with the Meryland stel thygiene. Id other than "naturat", or items 23s or 28s-f show event, the Medical Exercises must be neutred at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give A Yeer or Detes:			/es, specify Cu ☐ Yes 2√2√2√4		Rican, etc.)	Specify	ck, White, e	ack
5-0	72 hc	Completed	15. Decedent's E (Specify only highest gi	ducation		16a. Decede	nt's Usual Occi	upation e during most of work	kina	16b. Kind of Bi	usiness/Ind	ustry
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21	N G G	Con	12			Nurse	2			Nursi	ngg l	Homes
pu	9 70 5	Be	17. Fether's Neme (First, Middle, Las	t)				18. Mother's Nam	ne (First, Middle	, Meiden Sumen	10)	
Va	2 should be f end Mentel I is marked of raumatic eve	2	Benjamin W. Ha	11				Alice	Owens			
a	end la me		19a. Informent's Name/Reletionship	(Type, Print)		19b. Mailing	Address (Street	et and Number or Ru	ral Route Numb	er, City or Town,	Stete, Zip	Code)
2	end salth n 27 I		Samuel A. Stew	art/Son		1323	Chape.	lwood La	ne Sea	t Ples	ant,	Md.
re	T a a		20a. Method of Disposition		com	e of Disposi	tion (Neme of tory or other pi	lece)	Dete	20c. Location -	City or Tov	wn, Stete
Baltimore,	permit. Pages 1 Department of He Important: If itan any injury or oth		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of Cont	_IRemovel from State ftv)				emetery	1/15/9	9 Clin	ton,	Md.
atti	mit.		21. Signature of Funeral Service Lica			22.1	Name end Add	ress of Fecility			·	
Ö	Depariment important		(NOW)			Di	nn s	Sons 563	5 5236	C+ N	E DC	20010
	_		23a, Pert1. Enter the diseese, or con	nolicetions that cause	d the death						E DC	Approximate
	Physician /Medical		23a. Pert1. Enter the disease, or cor shock, or heert feilure. List only tmmediate Ceuse (Final disease or condition	one ceuse on eech					,		1	tritervel Between Onset end Deeth
	Examiner		resulting in death)	a. Carara		s e conseque	ence of):				1	
		ner		Advanc				tic Hear	t Dise	9256	1	10 yrs.
	the death certificate be executed y the attending physician end tched for use as the buriel-transit	Examiner	Sequentially list conditions.	b. —		s e conseque	1	oro noar	0 5150	dbc		10 115.
ó	an ea		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Poguer				Honrt En	ilumo		1	8 vrs.
68760,	ysic he b	Medical	that initieted events resulting in death) Lest	c. Neculi		s e conseque		Heart Fa	TTULE		1	8 yrs.
	ng ph	Wed	resulting in dealin, cost	Recent	Pneu	monia					i	
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	deat e att	Physician/	Pert II. Other significent conditions	contributing to death b	out not resulti	na in the und	erivina cause o	iven in Pert I.	23b. Dfd	tobacco uae co	ntribute to	the cause of death?
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	requires that been signed be should be dete	by F	Cerebrovascula	r Accide	nt					X		
Records,	v require been sig should b									en eutopsy		re eutopsy findings
00		let	Alzheimer"s Di	sease					perf	ormed?	con	oilable prior to inpletion of cause deeth?
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Vital	certificate rector, pag		Bipolar Illnes 25. Wes case referred to medical	S						Yes 2⊠No	10	Yes 2 No
5		o Be	exeminer?	Hospital:		2/0		26. Plece of Dee			40. 14	
of	Phys r this arai di	-	27. Manner of Deeth		ent 2 EF	8b. Time of	3□ DOA 28c. Ini			idenca 6 Oth)
O	Attanding r death. ector: After by the fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of fnju (Month, De	y Year)	Injury	28c. Inj W	ork? ∃Yes 2⊟No				
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Division	or Attand after death Director: /	Certification:	4 Homicide	28e. Pleca of In building, el	c. (Specify)	-,,	.,,,			wn, State)		
	To the Hospital or Atlanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one)	nysician: To the best minar: On the basis o end manner st	of examination	edge, death on end/or inves	ccurred et the stigetion, in my	time, dete end pleca, opinion, deeth occur	and due to the	cause(s) and me date end pleca,	enner es sta end due to	ated. the ceuse(s)
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended I tem #7, 1/8/99, WCHD,
1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** ARTHUR SCHEU JAN. 4, 1999 9:15AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Center; Genesis ElderCare Wicomico Salisbury, Md 6. Sex. 1 M 2 □ F If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Director 185-10-1149 -26 - 08Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10132 GOLF COURSE RD 21842 USA Funeral 2. Was Decedent Ever in U.S.
Amped Forces?
1 Dives 2 Do No
Iffes, Give
Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. À 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *na any Injury or other traumatic event, the Media page. Etementery/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT PAINTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be To LOUIS SCHEU ALICE JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33477 VIRGINIA SUNTUM 1127 SEMINOLE RD E BELLA VISTA JUPITER, FLA 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Durial 2 Cremation 3 Removal from State 1-8 4 ☐ Donation 5 ☐ Other (Specify) RIVERVIEW CEMETERY WILMINGTON, DE. 21. Signatupe of Fug 22. Name and Address of Facility ULLRICH FUNERAL HOME BERLIN, MD. 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between Onset and Death Physician /Medical Immediate Cause (Final come 37 disease or condition resulting in death) Examiner Examiner ement in be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot): 68760 Physician/Medical Due to (or as a consequenca of) Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yss 2 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy findings svailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 2 1 No 1 Yes 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical eleip! filled in by the funeral director. g. 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mennes of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

01

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ce

1104 HEALTHWAY DR., SALISBURY, MD. 21804

29d. Date signed (Month, Day, Year)

State Registrar 32. Registrar's Signature

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porce

29c. License number

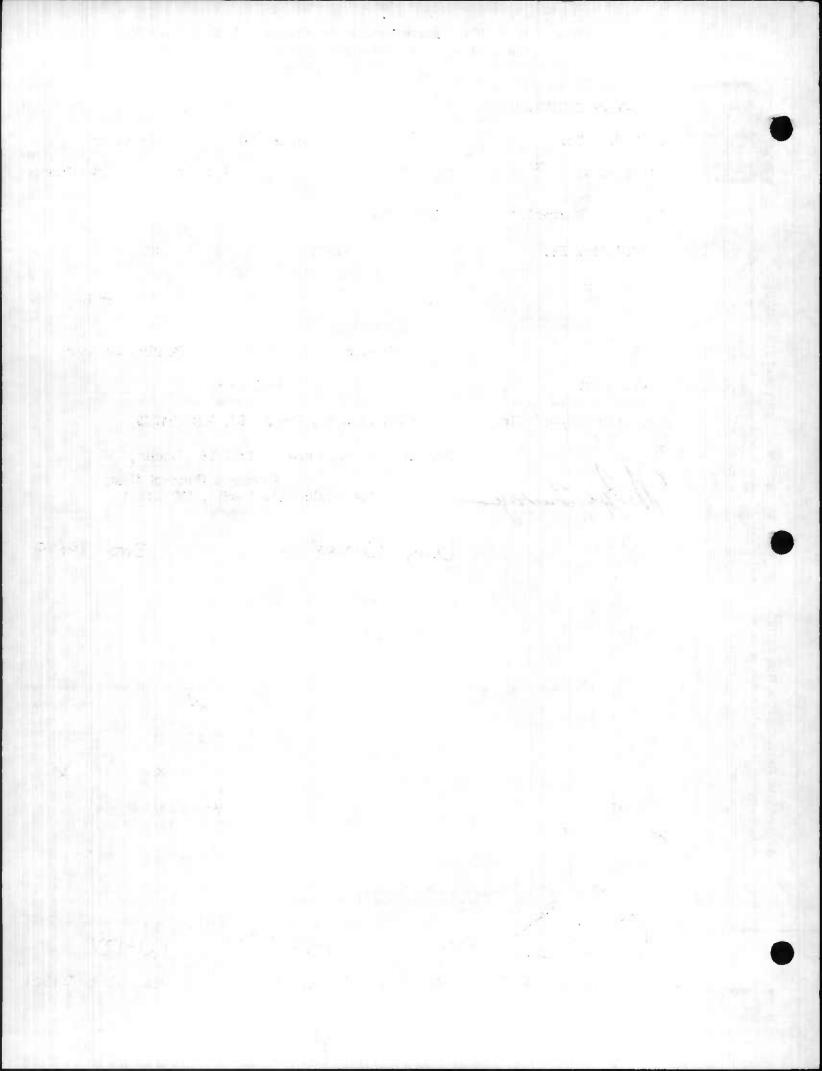
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Des Vear **Physician** ANTON SCHUMEYKO 99 12 7:20 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 5436 Pine St. Snow Hill Worcester If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Days 150 M 2□ F Months Director 88 214-32-0251 Ukraine Usual Residence of Deceder the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Worcester Snow Hill 1 XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5436 Pine St. 21863 USA Funeral deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or then any injury or other traumatic event, the Medical Examine. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: P 3 ☐ Widowed 4 ☐ Divorced white Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 3 Farmer Poultry Grower 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Anna Schumevko/ Wife 5436 Pine St. Snow Hill, MD 21863 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 1/15/99 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home Funeral Service Licensee 108 William st. Berlin, MD 21811 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximete Interval Between Onset and Death **Physician** 10/98 /Medical Immediate Ceuse (Final conces 3wo diseese or condition resulting in death) Examiner Due to (or as a consequenca of): Examiner pue buriel-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): that the death certificete be execu physician sthe buriel Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 88 9SN 20 23b. Did tobacco use contribute to the cause of death? the Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 12Nes 2 No 2 3 Probably 4 Unknown signed b þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? page 2 2 No 1 ☐ Yes ANo 1 Yes certificate Division of Vital Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) n.0. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Snyder 108 A Registrar's Signature 31. Date filed (MAN) State Registrar

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month HATTIE TOLSON 01 06 99 5:45 pm 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 KF 66 Yrs 578-44-6191 August 12, 1932 North Carolina Usual Rasidanca of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 Yes 2 No Maryland Prince George's Upper Marlboro 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4111 Tudor Road 20772 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Giva Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Merried 2 Merried 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elemantery/Secondary (0-12) College (1-4or 5+) 10th Nurse Assistant Government 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dance Williams, Sr. Bessie Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Tolson/Son 4111 Tudor Road, Upper Marlboro, Maryland 20722 Date 01/09 1999 20a. Mathod of Disposition 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Ramovel from State 4 Donation 5 Othar (Specify) Harmony Memorial Cemetery Landover, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility J.B. JENKINS FUNERAL HOME Na Perce 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Finel disaasa or condition resulting to daath) Due to (or as a consequence of) Due to (or as a consequence of): omycin resistent enteroccocus Vano Due to (or as a consequence of) Part II. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to disorder completion of caus of death? N/A on of cause

Physician /Medical **Examiner**

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Certification: To

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72 hours after

permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic avent, the Medical page.

21215-0020

Baltimore, Maryland

Box 68760,

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Hospital or Attanding P
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Examine Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Physician/Medical

acidosis 25. Was casa referred to medical axaminer?

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Yes 2 No tension 26. Place of Deeth (Check only one)

1 Yas 2 No 27. Mannar of Death LE Natural

2 Accident

4 Homicide

3 Suicida

5 Pending invastigation 6 Could not be datarmined

28h Tima of 28e. Data of Injury (Month, Day Year)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d, Describe how injury occurred

29a. Certifian (Check only one)

Certifying Phyalcian: To tha best of my knowledga, deeth occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated.

29b. Signature end title of certifier

29c. License number 34472 29d. Data signed (Month, Day, Year) 1699

Location (Street and Number or Rural Route Number, City or Town, State)

30. Nama and address of person who completed cause of death (Hern 23a) (Type, Print)

MD unne D. Diess 1500 Forest Glen Rd. Silver Sp. Md 20910

State Registrar

31. Data filed (Month, Day, Year)

JAN 1 1999

Registrar's Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

				Marylar		artment of rtificate o		ind M		Reg. No.	33 0	1995
Physicia /Medica	in	1. Decedent'a Name (First, Middle, Li	J,	Tayl	en				2. Date of Dea Month	Day (L	Year	B: 30 4h
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Funeral				Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 2	24 Hrs.	8. Date of Birt	h	9. Birthplace	(State or Foreign
Director		220-38-4456	18 M 2□F	5	4 Yrs.	Months Day	ys Hours	Min.	Month, Day July 23,	1944	Country) Washingto	n, D.C.
p .	-	Usual Residence of Decedent 10e. State 10b. County		100 Ci	ty, Town or Lo	ontion					104 6	nside City Limits
Aanyla			Coorgola		dover	Cation						Yes 2 No
the h	X -	Maryland Prince (seorde 2	Lan	dover	10f. Zip Code	9			10g. Citizen of V	What Country?	
3a or		7907 Greenleaf Ro	ad			207	85			U.S.A		
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offled very		9th 17. Father's Name (First, Middle, Las	t)			custoar		r'a Name	(First, Middle.	Maiden Suman		
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laryland 212 2 should be filed withi and Mental Hygiena. Is marked other than aumatic event, the M	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Meilir	ng Address (Str	eet end Numbe	r or Rura	l Route Numbe	r, City or Town,	Stete, Zip Cod	e)
2 p = 1		Catherine Harris	on/Mother		7907	Greenle	af Road	l, La	ndover	, Maryla	and 207	85
2 2 2 2		20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 [Removal from Sta		Place of Dispo cemetery, crer	sition (Name of netory or other)	olace)		Date 01/16	20c. Location -	City or Town,	State
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Baltimore, pemit. Pages 1 er Department of Hee Important: if them; any Injury or other page.		21. Signeture of Funeral Service Lice	Parce Parce	tie	J.	B. JENE	KINS FU	NERA		ver, Mar		20700
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middle, Last) 1435 January 7,1999 4c. County of Death 4b. City. Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 9. Birthplaca (Stata or Foraign Country) 6 Say 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 10 M 20 F Days 2|S-20-2511 Usual Rasidance of Dacedant Yrs. 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Nas 2 No Somerse 10f. Zip Coda 10g. Citizen of What Country? 10e. Street and Number 838 tor Was Dacedant Evar Armed Forcas? 1 Yas 2 No If Yas, Giva Yaar or Datas: 14. Race - Amaricen Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 1 Navar Married 2 Married 1 Yas 2 No Specify: Black 3 Widowad 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Sitter NUCSING 17. Fathar'a Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Jertrude 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Salisbury Md, 2180 y Place of Disposition (Nama of cematary, cramatory or other place) laylor Data 20a. Mathod of Disposition 1 ABurial 2 Cramation 3 Ramoval from State 1-12-99 4 ☐ Donation 5 ☐ Othar (Specify) marion ma emetary 21. Signatura of Funaral Sarvice Licansee 22. Nama and Addrass of Facility Bennie Smith Funeral Home P.O. Box 331 Pocomoke City, Md, 21851 0 23a. Part1. Enter the dicease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximata Interval Batween Onsat and Death immediata Causa (Final disaasa or condition rasulting in daath) Due to (or as a consequence of): Due to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 PNo 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of daath? 24a. Was an autopsy performed? 1 Yas 2 No 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) ↑ Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Yas 2 No

Division of Vital

Examiner the ettending physician end hed for use es the buriel-transit To the Hospital or Attanding Phys within 24 hours after death.

To the Funeral Director: After this funeral

Physician

/Medical

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after dean Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". Colon and Injury or other traumatic events.

Physician /Medical

Examiner

215-20-2517

Funeral Director

λq

Completed

Physician/Medicai þ Completed Be Certification: To

25. Was cesa rafarrad to medicel examinar? 1 Yas 2 No

27. Mannar of Baath 1 Matural

29a, Cartifiar

Medical

2 Accidant 6 Could not be datarminad 3 Suicida 4 Homicida

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Location (Streat and Number or Rural Routa Number, City or Town, Stata)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatura and titla of certifiar

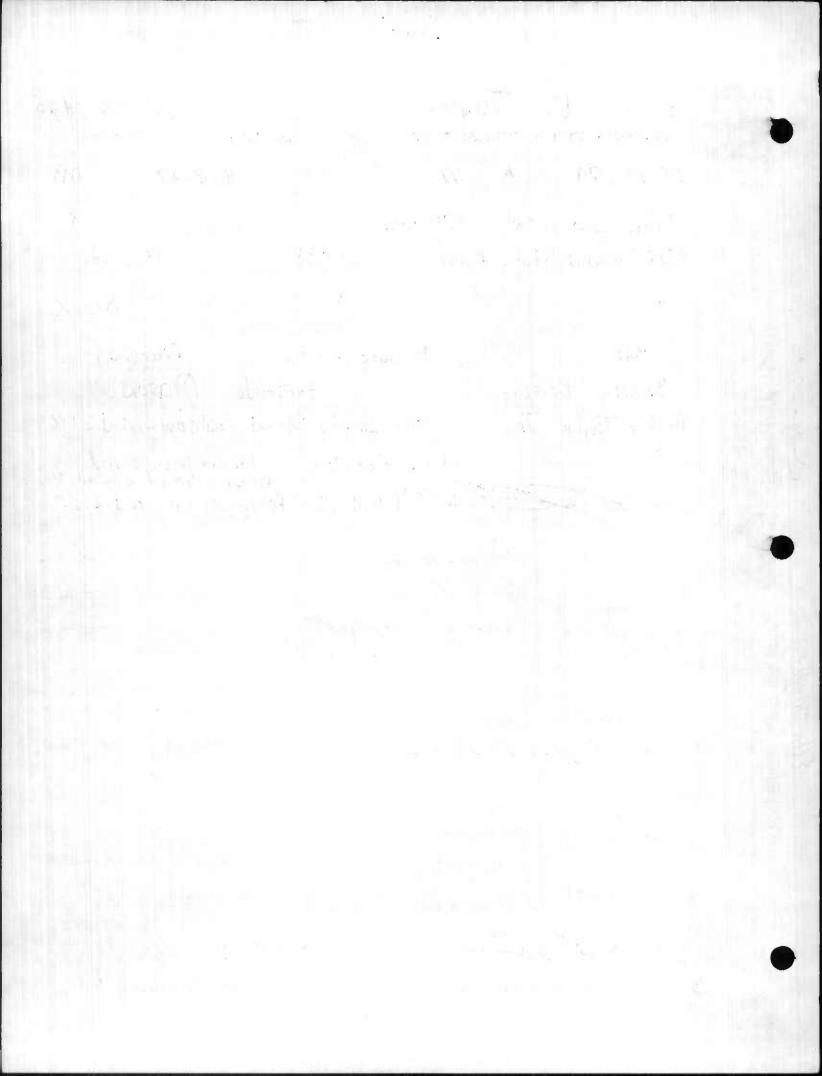
29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

William 31. Data filad (Month, Day, Yaar) JAN 13

M. D 32. Ragistrar's Signatura 1104 Healthway

Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

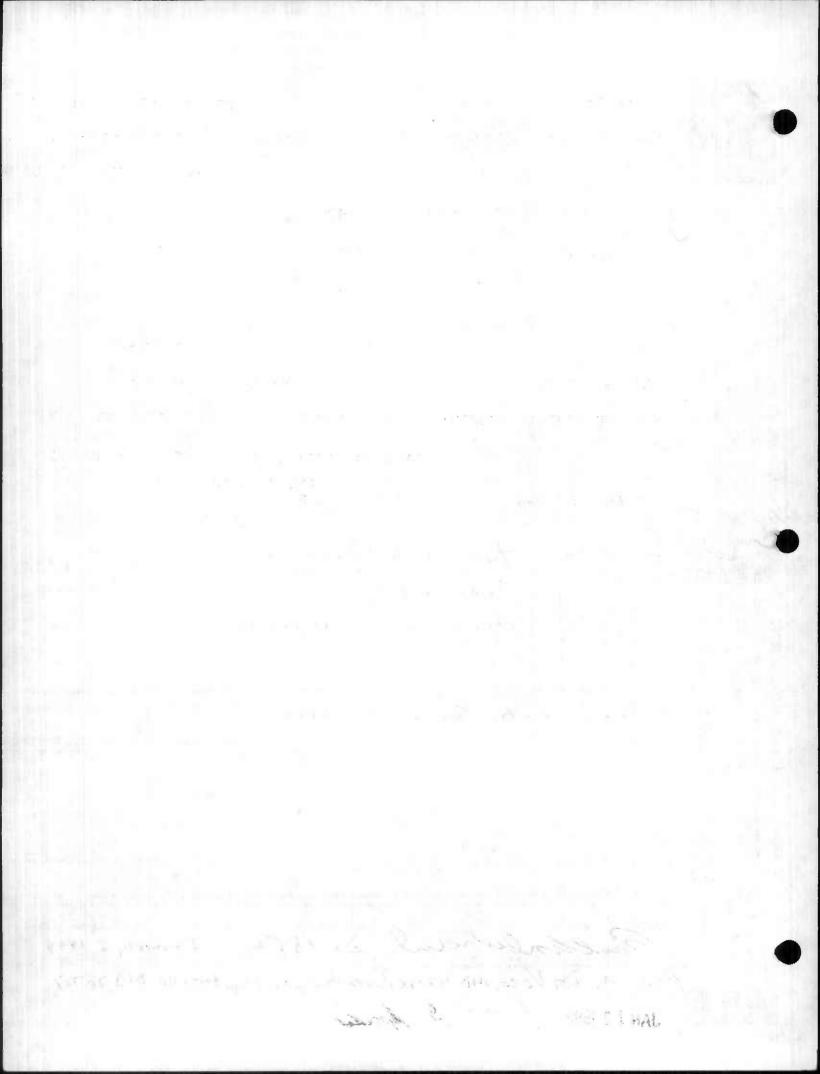
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth **Physician** JAN 4, Tay 999 Yaar IRENE TAYLOR 9:30PM /Medical 4a. Fecility Nema (If not institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GLADYS SPELLMAN NURSINGS HOME PRINCE GEORGES CHEVERLY, MD 8. Date of Birth (Month, Day, Year)
OCT 2, 1907 If Under 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. 7. Aga (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Deys 1□M 2√F 91 NORTH CAROLIN 2848 246 26 Yrs Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show MD PRINCE GEORGES CAPITAL HEIGHTS XXYes 2 No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 20743 USA 414 HILL RD Funeral Items ? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) 11. Marital Status 14. Race - Amaricen Indien, Bleck, White, etc. 7 is marked other than "natural", or iten traumatic event, the Medical Examiner filed within 72 hours efter 1 Never Merried 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Completed by BLACK 3 Widowed 4 □ Divorced Specify: 15. Decedent's Education (Spacify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Hygiene. INSURANCE AGENT Baltimore, Maryland 17. Fether's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) .. Peges 1 and 2 should be fitterned of Health end Mental Health end Mental Health is marked oth Jury or other traumetic even Be CHARLES REID HOWELL ELIZABETH 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 WYLD DR. UPPER MARLBORGH, MD ARNELL MUMFORD (GRANDSON) 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Buriei 2 Cremetion 3 Removei from Stete permit. Pege Depertment of Important: If any Injury or once. GEORGE WASHINGTON M.PJAN11,1999 PARAMUS:N.J. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility
RALPH WILLIAMS FUNERAL SVC 517 11th ST.S.E. 234. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximate Interval Bety Onsat end Death **Physician** Immediate Ceusa (Final diseese or condition resulting in death) /Medical Joiration **Examiner** Due to (or es e consequence of) Dy on hapea week The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest pue Box 68760, heimeris Physician/Medical the Due to (or as a consequence of). P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Cardiovnico las Teriosclarotic Records, ģ 24b. Were autopsy findings aveileble prior to completion of causa of deeth? Completed 24a. Wes en eutopsy performed? After this certificate has 1 Yas 2 No of Vital Physician: Be 25. Wes cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No the funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Division or Attending 5 Pending investigation 1 Haturel death. 1 Yas 2 No NIA 2 Accident s after death 6 Could not be 3 ☐ Suicide in by t 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital
within 24 hours a
To the Funeral C
completely filled Medical 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es stated.

| Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29b. Signature and titla of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) DEVORE, MD 4203 QUEENSSURY Rd Hyattsville MD 20781 31. Date filed (Month, Day, Year) 32. Ragistrer's Signeture

DHMH 16 Rev 6/95

Registrar

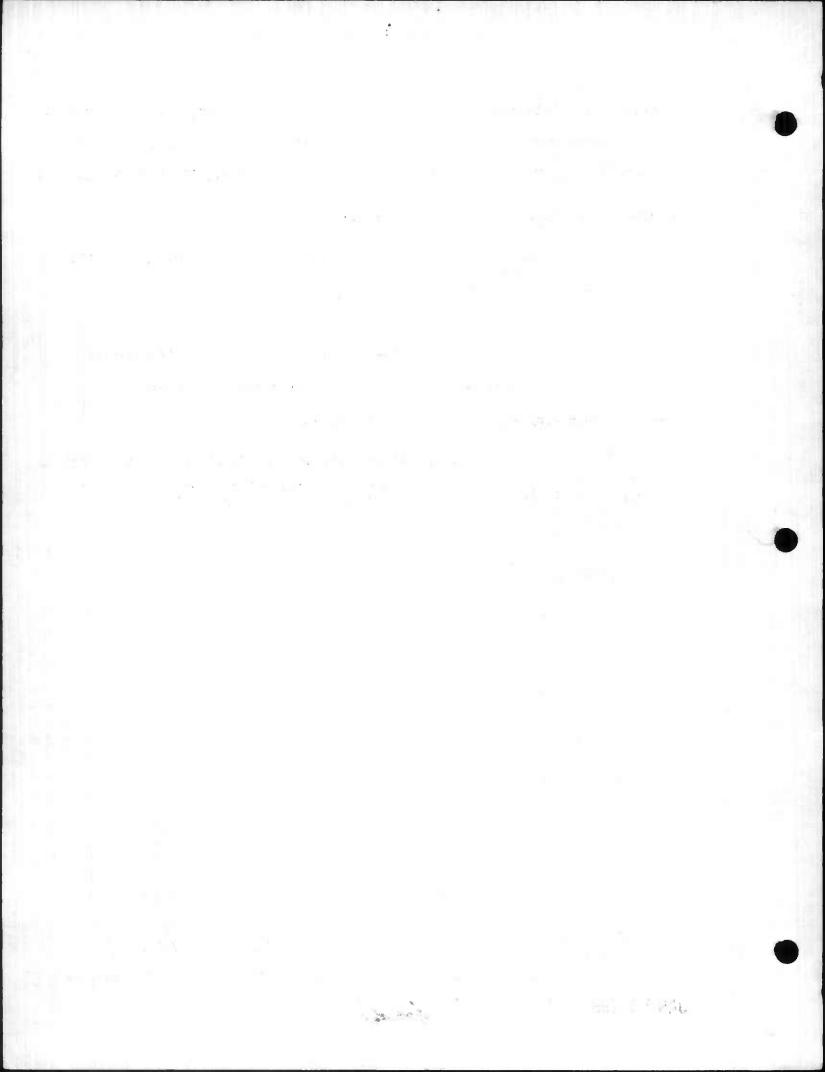
JAN 1 3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

n)				2. Data of D	eath	3. Tima of Deat
	Diego I. Va					Month	Dey	Yeer
al -	4a. Fecility Neme (If not institution, giva			(4b. City, Town, or L	Januar		999 9:35 A.
er	8401 Dangerfield	Table of the second				oodion of Boo		
	5. Social Security Number 6. Sec		. last birthday)	If Under 1 Yaar	Clinton If Undar 24 Hrs.	R Date of B		e George's
	231-36-9404	XM 2□ F	78 Yrs.	Months Deys	Hours Min.	8. Deta of B (Month, D April	ay, Year) 19, 1920	9. Birthplace (Stata or Ford Country)) Switzerland
	10a. Stete 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Lim
ctor	Maryland Prince Ge	orge's	C	linton				1)(Yas 2 🗆
e l	10e. Street end Number			10f. Zip Code			10g. Citizen of	Whet Country?
8	8401 Dangerfield	P.1.		207:	35		U.S.A./S	Switzerland
in e	11. Maritel Stetus		J,S. 13.	Was Decedent of I	Hispenic Origin? (Spen. Mexican, Puerte	pecify Yas or N	0- 14. Red	ce - American Indian, ck, White, etc.
2	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2/2/No If Yes, Give Year or Detes:				, , , , , , , , ,	Specifi	
9	15. Decedent's Edu	cation	18e. Dece	dent's Usuel Occup	petion	72.7	16b. Kind of B	usiness/Industry
D e			(Give	kind of work done DO NOT use retire	during most of world)	king		
E O	12	Oollega (1-40/ 54)	Cabi	net Maker	r		Self-Er	nploved
	17. Fether's Name (First, Middla, Last)				18. Mother's Nem	ne (First, Middle		
0	Angelo	Valchera			Marie A	dele Ma	rtinola	
	19e. Informent's Neme/Reletionship (Ty	pe, Print)	19b. Meill	ng Address (Street	and Number or Ru	ral Routa Numi	ber, City or Town,	State, Zip Code)
	Ogretta T. Valchera	a/Wife	same	as item	10			
			Placa of Dispo	sition (Nama of	ice)	Dete	20c. Location	City or Town, Stata
					1	3/1000	Alexanda	cia Virginia
-								
	Man 11/1/2	1	G	eorge P.	Kalas Fu	neral H	lome, P.A	Α.
\dashv	Day Follow House	~~	6	160 Oxon	Hill Rd.	, Oxon	Hill, MI	20745 Approximate
Je .	Immediate Cause (Final disease or condition resulting in deeth)	100000			NOMA		<u> </u>	Onset end Death
kamin	Sequentially list conditions,	Due to (or es e consec	quence of):				1
	cause. Enter Underlying Cause (Disease or Injury							
200	thet initiated events resulting in deeth) Lest	Dua to (or as a consec	juence of):				
ğ Z								
and		J						
	Pert II. Other significant conditions cor	tributing to death but not re	sulting in the u	ndarlying cause gi	ven in Pert i.	2	1	ntribute to the causs of dea 3 Probably 4 Unkn
						24a. We per	s an autopsy formed?	24b. Were eutopsy finding evallable prior to completion of cause of deeth?
E						10	Ves 2K No	1 ☐ Yas 2 ☐ No
	25. Wes case referred to medical				28 Place of Dag			10100 20100
	examiner?	lospitel:	3 EB/Outpatler	N 3 DOA OH	hor:			os (Canaiki)
	73					Λ		
0	1 Netural 5 Pending Invastigation	(Month, Day Year)	Injury					
LINCS	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At I building, etc. (Spec	nome, ferm, str	reet, factory, office		281. Location City or To	(Street and Numl own, Stata)	ber or Rural Route Number,
edical	29e. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination	lician: To the best of my kn ear: On the basis of examin- and menner stated.	owledge, deetl ation and/or in	n occurred et the ti vestigetion, in my o	me, dete end piece opinion, deeth occu	end due to the red at tha time	cause(s) end ma , date end piece,	anner as steted. and due to the cause(s)
	29b. Signature and title of certifiar					4	29d. Daje signe	d (Month, Day, Year)
	Re on	mo		D	43341		1/12	199
-	20 Name and od and	malalad according to the state of	m 02c) /=	Dulati		U	1/3/	(/
	RITA GUOTA	no 2924	LUAN!	VAR D	ROAD #	201 0	LINTAL	U MA 20728
	medical cermination. To be completed by ringstoral/medical Examinet	Usual Residence of Decedent 10a. Stete 10b. County Maryland Prince Get 10e. Street end Number 8401 Dangerfield 11. Maritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade) 15. Decedent's Edu (Specify only highest grade) 16. Informent's Name (First, Middla, Last) Angelo 19e. Informent's Neme/Reletionship (Ty Ogretta T. Valchera 20e. Method of Disposition 1 Burial 2 Cramation 3 R 4 Donetion 5 Other (Specify) 21. Signature of Funaral Service List only or 15. Decedent's Edu (Specify only highest grade) 16. December of Specify) 17. Fether's Name (First, Middla, Last) Angelo 19e. Informent's Neme/Reletionship (Ty Ogretta T. Valchera 20e. Method of Disposition 1 Surial 2 Cramation 3 R 4 Donetion 5 Other (Specify) 21. Signature of Funaral Service List only or 18. Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Lest 25. Wes case referred to medical examiner? 1 Yes 2 No 26. Wes case referred to medical examiner? 1 Yes 2 No 27. Menner of Deeth 1 Netural 5 Pending Invastigation 3 Suickde 4 Homicide determined 29b. Signature and title of certifiar Usual Residence of Decedent 10a. Stele 10b. County Maryland Prince George's 10c. Co Maryland Prince George's 11. Martel Stetus 12. Wes Decedent Evar in It Armed Forcas? 11. Prese ZONO If Yes, Give Year or Detes: (Specify only highest grade completed) Elementery/Secondary (0-12) 12. Collega (1-4or 5+) 12. The Steries Name (First, Middla, Last) Angelo Valchera 19e. Informent's Nema/Reletionship (Type, Print) Ogretta T. Valchera/Wife 20e. Method of Disposition 1	Usual Residence of Decedent 10e. Stele 10b. County Maryland Prince George's 10e. Street end Number 8401 Dangerfield Pl. 11. Maritel Stetus 1	Usual Residence of Decedent 10a, Stete 10b, County Maryland Prince George's Clinton 8 401 Dangerfield Pl. 11. Martiel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced Specify only highest grade completed) [Specify highest grade completed) [Sp	231-36-9404 78 78 78 78 78 78 78 7	231-35-94.04 78 11 10c. City, Town or Location 10c. City, Town or Location 10c. Steve and Number 10c. City, Town or Location 10c. City, Town	Libural Residence of Decaded 10s. Stelle 10s. Courty 10s. Courty	

Registrar



1. Decedent's Name (First, Middle, Last) GREENE O. WILLIAMS

2. Data of Death January 07

3. Tima of Death 4:35 AM

4a Facility Nama (If not institution, give street and number) Knollwood Manor Nursing Home

4b. City, Town, or Location of Death Millersville

1999 4c. County of Death

Funeral Director

ehow

th and Mental Hygiene.
7 is marked other than "natural", or form 23a or 28a-f ehov trenmatic event, the Medical Exercise must be notified.

filed within 72 hours efter death

Pages 1 and 2 should be family and Mental Part: If item 27 is marked of

or other t

permit. Page Department of Important: If eny Injury or once.

Physician /Medical

Examiner

sician and burial-transit

physician the buria

igned by the a

The law requires that the death certificate be assecuted

P.O. Box 68760.

Division of Vital Records.

or Attending Physicien:

this funeral

After 1

filled in by

ipmpietely

death.

To the Hospital or Attendi within 24 hours after death To the Funeral Director: A

Examiner

Physician/Medical

Completed by

Be

Certification: To

edical

Baitimore, Maryland 21215-0020

the Maryland

184-16-8636 Usual Residence of Decedent 10b. County

If Under 1 Year | If Under 24 Hra. 7. Age (In yrs. last birthday) Months Days Hours 77

Anne Arundel 9. Birtholaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May 11, 1921 South Carolina

10a State

Director

Funeral

p

Completed

Be

Maryland Prince George's

6. Sex

180 M 2□ F

10c, City, Town or Location Capitol Heights 10d Inside City Limite

10e. Street and Number

10f. Zip Code 20743

1 X Yas 2 □ No 10g. Citizen of What Country?

902 Logwood Road

11. Marital Status 1 ☐ Never Married 2 Married 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yes 2 Ø No Specify:

14. Race - American Indian, Black, White, etc. Black Specify:

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

12th

Correctional Officer

Government

U.S.A.

17. Father's Nama (First, Middle, Last)

Greene O. Williams, Sr.

Jannie Moore

18. Mother's Name (First, Middle, Meiden Sumema)

19a. Informant's Name/Relationship (Type, Print) Mary L. Williams/Wife

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 902 Logwood Road, Capitol Heights, Maryland 20743

20a. Mathod of Disposition

1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place) Chesapeake Crematory

20c. Location - City or Town, State 01709 Beltsville, Maryland 1999

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximate

to (or es a consequence of)

Approximata Interval Batween Onsat and Daath

Immediata Causa (Final disease or condition resulting in death)

Due to (or as a consequence of)

26. Place of Death (Check only one)

4 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of)

23b. Did tobacco use contribute to the cause of death?

end stage

Alzheimers Disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yaa 2 No 24a. Was an autopsy performed?

sheumatoid arthritis

2 No

24b. Ware autopsy findinga available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

3 Probably 4 Unknown

25. Was case referred to medical axaminar?

1 Yas 2 No

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Data of Injury (Month, Day Year)

28c. Injury at Work?

Other: Nursing Homa 5 | Rasidence 6 | Other (Specify) 28d. Describe how injury occurred

B-A Blud Arnold MD 21012

27. Menner of Death 1 Natural 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be

1 | Yes 2 | No 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(5) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

MID 31. Data filed (Month, Pay, Year) 32. Registrar's Signature

State Registrar

March State Comment

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month Day 1129 AM **Physician** JANUARY OCIT Johnnie Edward Williams /Medical 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva straat and number) Examiner COUTER HOSPITAL PRINCE GEORGES PRINCE GEORGES CHEVERLY If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 110 M 2□ F Maryland 218-20-2136 Director 70 June 3, 1928 Usual Rasidance of Dacedeni the Meryland r 28a-f show 10c. City. Town or Location 10d. Insida City Limits 10a. Stata 10b. County 1 Yas 2 No Directo Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? with r than "natural", or items 23s or the Medical Examiner must be 20743 U.S.A. 711 71st Avenue Funerai deeth Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 12. Was Dacedant Ever in U,S. Armed Forcas? 11. Marital Status Black, Whita, atc. Armed Forces?
1 ☑ Yas 2 ☐ No
If Yas, Giva
Yaar or Datas: 2/51-1/53 filed within 72 hours efter 1 Nevar Married 2 Married Maryland 21215-0020 1 Yas 2 No Specify: Specify. þ 3 Widowad 4 Divorced Black Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Spacify only highast grada complated) Hygiene. Etamantary/Secondary (0-12) Collega (1-4or 5+) 9th Maintenance Worker Government i. Peges 1 and 2 should be filed w timent of Health and Mental Hygie tant: If them 27 is marked other ti jury or other traumatic avent, to 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Babe Williams Mamie Brooks 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a, Informant's Name/Ralationship (Type, Print) 2339 Pitts Place S.E., #202, Washington, D.C. 20020 Sharon Minor/Daughter Baltimore. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 01/12 Burial 2 Cramation 3 Ramoval from Stata Department of Important: If any Injury or Maryland Veterans Cemetery 4 Donation 5 Othar (Specify) 1999 Cheltenham, Maryland 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensea J.B. JENKINS FUNERAL HOME Ken ance 7474 Landover Road, Landover, Maryland 20785 he 23a. Part1. Enter the dispesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarvat Between Onset and Death **Physician** /Medical Immediata Causa (Final . HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE disaasa or condition rasulting in daath) Examiner Dua to (or as a consaquanca of) Examiner physician end the buriel-frensit that the death certificete be executed Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of): ettending ph Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 9 s been signed by the should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MELLITUS Records, by 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy Completed page 2 2 No 1 ☐ Yas 2 ☐ No 1 Yas certificate Division of Vital Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) axaminar? Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 10 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA

Certification:

 Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director, pletely filled in by

Within 2 To the Comple

State Registrar

edical

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5 Panding invastigation

6 Could not be

DME

28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

Injury

29c. Licansa number

1 Yas 2 No

29d. Data signed (Month, Day, Year)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how Injury occurred

blefed causa of de 30. Nama and addrass of person who co filliam 23a) (Type, Print) GOLVE 2001 JK

TAL PRIVE, CHEVERLY

28c. injury at Work?

20

31. Data filed (Month

27. Mannar of Death

1 Natural

2 Accidant 3 Suicida

4 Homicida

29a, Cartifian

29b. Si

2. Registrar's Signatura